

02910

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Point of Rocks</b>			c. LENGTH OF STAY IN 1b <b>Life</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>D.</b> Last <b>ANDERSON</b>			4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>19 57</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 Feb 1889</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min. <b>68</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Trackman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Anderson</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Baker</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-07-7658</b>		17. INFORMANT <b>Mrs. Lillie E. Anderson</b> Address <b>(Same as item #1)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nephritis</b> DUE TO (b) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>3 Months</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>Jan. 15, 19 57</b> to <b>March 19, 19 57</b> , that I last saw the deceased alive on <b>March 16, 19 57</b> , and that death occurred at <b>3:40 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>115 E. Potomac St., Brunswick, Md.</b> DATE SIGNED <b>3-20-57</b>					
ACTUAL SIGNATURE _____ M.D. <b>Ralph M. Thompson</b>					
PHYSICIAN'S NAME (Type) <b>Ralph M. Thompson, M. D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>21 March 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Point of Rocks, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			24a. REC'D BY REGISTRAR <b>DATE 22 March 1957 - Elizabeth B. Heck</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02872 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02881

Reg. Dist. No.

121

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <del>Frederick</del> <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Matina</b> Middle <b>John</b> Last <b>Argyropais</b>				4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 29, 1899</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b>		IF UNDER 24 HRS. Hours <b>57</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Greece</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Greece</b>							
13. FATHER'S NAME <b>John Argyropais</b>				14. MOTHER'S MAIDEN NAME <b>Helen L. Stamon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Lemonis John Argyropais</b> Address <b>Mt Airy R.F.D 4</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B.O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B.O. Thomas</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3/8/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood</b>	
				22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co., Riverdale, B.M.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>MAR 8 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Clay. Tucker</b>			

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2

RECEIVED

BUREAU V. S.

MAR 8 1967

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: Frederick

2. Sex: Male

3. Age: 57

4. Date of Death: March 1, 1967

5. Place of Death: Frederick Memorial Hospital

6. Cause of Death: Myocardial Infarction

7. Manner of Death: Natural

8. Signature of Examiner: James John Atterbury

9. Signature of Physician: James John Atterbury

10. Signature of Coroner: James John Atterbury

11. Signature of Medical Examiner: James John Atterbury

12. Signature of Pathologist: James John Atterbury

13. Signature of Toxicologist: James John Atterbury

14. Signature of Forensic Anthropologist: James John Atterbury

15. Signature of Forensic Dentist: James John Atterbury

16. Signature of Forensic Psychologist: James John Atterbury

17. Signature of Forensic Psychiatrist: James John Atterbury

18. Signature of Forensic Social Worker: James John Atterbury

19. Signature of Forensic Nurse: James John Atterbury

20. Signature of Forensic Pharmacist: James John Atterbury

21. Signature of Forensic Chemist: James John Atterbury

22. Signature of Forensic Biologist: James John Atterbury

23. Signature of Forensic Geologist: James John Atterbury

24. Signature of Forensic Meteorologist: James John Atterbury

25. Signature of Forensic Astronomer: James John Atterbury

26. Signature of Forensic Historian: James John Atterbury

27. Signature of Forensic Linguist: James John Atterbury

28. Signature of Forensic Musicologist: James John Atterbury

29. Signature of Forensic Philologist: James John Atterbury

30. Signature of Forensic Philosopher: James John Atterbury

31. Signature of Forensic Scientist: James John Atterbury

32. Signature of Forensic Technologist: James John Atterbury

33. Signature of Forensic Engineer: James John Atterbury

34. Signature of Forensic Architect: James John Atterbury

35. Signature of Forensic Designer: James John Atterbury

36. Signature of Forensic Artist: James John Atterbury

37. Signature of Forensic Craftsman: James John Atterbury

38. Signature of Forensic Farmer: James John Atterbury

39. Signature of Forensic Fisherman: James John Atterbury

40. Signature of Forensic Hunter: James John Atterbury

41. Signature of Forensic Miner: James John Atterbury

42. Signature of Forensic Sailor: James John Atterbury

43. Signature of Forensic Soldier: James John Atterbury

44. Signature of Forensic Worker: James John Atterbury

45. Signature of Forensic Teacher: James John Atterbury

46. Signature of Forensic Doctor: James John Atterbury

47. Signature of Forensic Lawyer: James John Atterbury

48. Signature of Forensic Judge: James John Atterbury

49. Signature of Forensic Jury: James John Atterbury

50. Signature of Forensic Witness: James John Atterbury

51. Signature of Forensic Victim: James John Atterbury

52. Signature of Forensic Perpetrator: James John Atterbury

53. Signature of Forensic Suspect: James John Atterbury

54. Signature of Forensic Accused: James John Atterbury

55. Signature of Forensic Defendant: James John Atterbury

56. Signature of Forensic Plaintiff: James John Atterbury

57. Signature of Forensic Plaintiff's Attorney: James John Atterbury

58. Signature of Forensic Defendant's Attorney: James John Atterbury

59. Signature of Forensic Prosecutor: James John Atterbury

60. Signature of Forensic Judge: James John Atterbury

61. Signature of Forensic Jury: James John Atterbury

62. Signature of Forensic Witness: James John Atterbury

63. Signature of Forensic Victim: James John Atterbury

64. Signature of Forensic Perpetrator: James John Atterbury

65. Signature of Forensic Suspect: James John Atterbury

66. Signature of Forensic Accused: James John Atterbury

67. Signature of Forensic Defendant: James John Atterbury

68. Signature of Forensic Plaintiff: James John Atterbury

69. Signature of Forensic Plaintiff's Attorney: James John Atterbury

70. Signature of Forensic Defendant's Attorney: James John Atterbury

71. Signature of Forensic Prosecutor: James John Atterbury

72. Signature of Forensic Judge: James John Atterbury

73. Signature of Forensic Jury: James John Atterbury

74. Signature of Forensic Witness: James John Atterbury

75. Signature of Forensic Victim: James John Atterbury

76. Signature of Forensic Perpetrator: James John Atterbury

77. Signature of Forensic Suspect: James John Atterbury

78. Signature of Forensic Accused: James John Atterbury

79. Signature of Forensic Defendant: James John Atterbury

80. Signature of Forensic Plaintiff: James John Atterbury

81. Signature of Forensic Plaintiff's Attorney: James John Atterbury

82. Signature of Forensic Defendant's Attorney: James John Atterbury

83. Signature of Forensic Prosecutor: James John Atterbury

84. Signature of Forensic Judge: James John Atterbury

85. Signature of Forensic Jury: James John Atterbury

86. Signature of Forensic Witness: James John Atterbury

87. Signature of Forensic Victim: James John Atterbury

88. Signature of Forensic Perpetrator: James John Atterbury

89. Signature of Forensic Suspect: James John Atterbury

90. Signature of Forensic Accused: James John Atterbury

91. Signature of Forensic Defendant: James John Atterbury

92. Signature of Forensic Plaintiff: James John Atterbury

93. Signature of Forensic Plaintiff's Attorney: James John Atterbury

94. Signature of Forensic Defendant's Attorney: James John Atterbury

95. Signature of Forensic Prosecutor: James John Atterbury

96. Signature of Forensic Judge: James John Atterbury

97. Signature of Forensic Jury: James John Atterbury

98. Signature of Forensic Witness: James John Atterbury

99. Signature of Forensic Victim: James John Atterbury

100. Signature of Forensic Perpetrator: James John Atterbury

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02882

02873

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>349 Madison Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>ROMER</b> Last <b>BARNES</b>				4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 24, 1877</b>	
9. AGE (In years last birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>		IF UNDER 24 HRS. Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Samuel Barnes</b>				14. MOTHER'S MAIDEN NAME <b>Ella May Kelly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-10-5025</b>		17. INFORMANT <b>Mrs. Bruce M. Palmer, 349 Madison Street, Frederick, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4:20.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio sclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>20 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/10</b> , 19 <b>52</b> , to <b>3/2</b> , 19 <b>52</b> , that I last saw the deceased alive on <b>3/2</b> , 19 <b>52</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Bldg., Frederick, Md.</b> DATE SIGNED <b>3/4/1957</b>							
ACTUAL SIGNATURE <b>L. R. Schoolman</b>				M.D. <b>Professional Bldg., Frederick, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Louis R. Schoolman</b>				Same as above			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>March 5, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE 5 March 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>	

BUREAU V. S.

MAR 2 1957

RECEIVED



02874

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b over 60 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 235 East Church Street				d. STREET ADDRESS 235 E. Church Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Bertha Ellen Blackston				4. DATE OF DEATH Month Day Year March 11 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-3-1878		9. AGE (In years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eyster W. Edmonds				14. MOTHER'S MAIDEN NAME Ida M. Rice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Robt. P. Hocker (sister) Dayton-Ohio			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that I attended the deceased from <u>Oct. 22, 1956</u> to <u>March 11, 1957</u> , that I last saw the deceased alive on <u>March 11, 1957</u> , and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>A. A. Pearre</u> M.D. <u>4 E. Church St.-Frederick-Md.</u> PHYSICIAN'S NAME (Type) <u>Dr. A.A. Pearre</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-14-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick-Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. E. Cline &amp; Son</u> ADDRESS Frederick-Maryland				24a. REC'D BY REGISTRAR DATE <u>14 March 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

181

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1912		BALTIMORE		MD		MD		USA	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		RE-MARRIED		RE-MARRIED		RE-MARRIED	
DATE OF MARRIAGE		JAN 15 1912		JAN 15 1912		JAN 15 1912		JAN 15 1912		JAN 15 1912		JAN 15 1912		JAN 15 1912	
PLACE OF MARRIAGE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE OF MARRIAGE		MD		MD		MD		MD		MD		MD		MD	
COUNTRY OF MARRIAGE		USA		USA		USA		USA		USA		USA		USA	
DATE OF DEATH		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957	
PLACE OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE OF DEATH		MD		MD		MD		MD		MD		MD		MD	
COUNTRY OF DEATH		USA		USA		USA		USA		USA		USA		USA	
CAUSE OF DEATH		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL	
DATE OF REPORT		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957	
PLACE OF REPORT		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE OF REPORT		MD		MD		MD		MD		MD		MD		MD	
COUNTRY OF REPORT		USA		USA		USA		USA		USA		USA		USA	
REPORTED BY		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF REPORT		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957	
PLACE OF REPORT		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE OF REPORT		MD		MD		MD		MD		MD		MD		MD	
COUNTRY OF REPORT		USA		USA		USA		USA		USA		USA		USA	

BUREAU V. 3

MAR 18 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02884

02875

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>About 50 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>440 West South Street</b>				d. STREET ADDRESS <b>452 West South Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>Bender</b> Last <b>Burck</b>			4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>19 57</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-30-1887</b>		9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>J. Henry Bender</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Blackston</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Md.</b> <b>Miss Helen Burck-440 W. South St.-Frederick-</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Breast</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>8 m</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>10-1</b> , 19 <b>56</b> , to <b>3-8</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-8</b> , 19 <b>57</b> , and that death occurred at <b>8:25 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>30 West All Saints St.-Frederick-Md.</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>U.G. Bourne Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. U.G. Bourne-Jr.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-11-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. C.E. Cline &amp; Son</b> ADDRESS <b>Frederick-Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE 11 March 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Hark</b>	

18

MAR 12 - 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>2 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. STREET ADDRESS <b>221 East Fifth Street</b>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>LEROY</b> Last <b>CECIL</b>				4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6 July 1877</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Levin Cecil</b>				14. MOTHER'S MAIDEN NAME <b>Bettie Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Charles M. Norwood</b> Address (Same as Item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia (terminal)</b> <b>204.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Lymphatic Leukemia</b> DUE TO (c) <b>14 years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April</b> , 1955, to <b>March 7</b> , 1957, that I last saw the deceased alive on <b>March 7</b> , 1957, and that death occurred at <b>11 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert S. Turner, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>7 E. Church St., Frederick, Md.</b>			
DATE SIGNED <b>3-8-57</b>							
PHYSICIAN'S NAME (Type) <b>Robert S. Turner, Jr., M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12 March 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. L. Burdette, Hyattstown, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>11 March 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>			

MAR 12 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02911 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02886

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lime Kiln</b> c. LENGTH OF STAY IN lb <b>32 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lime Kiln</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <b>WALTER</b> Middle <b>CECIL</b> Last <b>CECIL</b>				<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>25</b> , Year <b>1957</b>											
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>21 April 1882</b>		<b>9. AGE</b> (In years last birthday) <b>74</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired-Foreman</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Road Construction</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>Frank O. Cecil</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Ida Smith</b>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>217-10-9099</b>				<b>17. INFORMANT</b> <b>Walter Smith Cecil</b> (Same as item #1)							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Strangulation by hanging</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)												INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <i>B. O. Thomas</i> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>												<b>DATE SIGNED</b>			
<b>EXAMINER'S NAME (Type)</b> <b>B. O. Thomas, M. D.</b>												<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>												<b>26 March 1957</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>27 March 1957</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Methodist Cemetery</b>				<b>22d. LOCATION</b> (City, town, or county) (State) <b>Clarksburg, Maryland</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>								<b>24a. REC'D BY REGISTRAR</b> <b>DATE 26 March 1957 - Elizabeth B. Heck</b>		<b>24b. REGISTRAR'S SIGNATURE</b>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



RECEIVED

MAR 27 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02912

## CERTIFICATE OF DEATH

02887

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL BURKITTSTVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL BURKITTSTVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS —	
3. NAME OF DECEASED (Type or print) <u>NANCY</u> First <u>M</u> Middle <u>CONNER</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-13-56</u>
9. AGE (In years last birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>2</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Conner</u>		14. MOTHER'S MAIDEN NAME <u>Chas. C. Armstrong</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>John E. Conner Knoxville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>490X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Other Media</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/1</u> , 19 <u>57</u> , to <u>3/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/1</u> , 19 <u>57</u> , and that death occurred at <u>12:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Louetta Mills, Md</u> DATE SIGNED <u>3/2/57</u>			
ACTUAL SIGNATURE <u>W. B. Carpenter</u>		PHYSICIAN'S NAME (Type) <u>W. B. CARPENTER</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-4-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Park Heights</u>		22d. LOCATION (City, town, or county) (State) <u>Brunswick Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. J. Tate Brunswick Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>Car. Lewis</u>			

RECEIVED

02877

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Since 1948</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Three Pines Nursing Home</b>				e. STREET ADDRESS <b>313 North Market Street</b>			
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>G.</b> Last <b>COOLEY</b>				4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>19 May 1869</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Cooley</b>				14. MOTHER'S MAIDEN NAME <b>Mary Nicholson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT <b>Millard I. Cooley, 3 Mt. Olivet Bld., Frederick, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>June 1, 1956</b> to <b>March 11, 1957</b> , that I last saw the deceased alive on <b>March 9, 1957</b> and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7 E. Church St., Frederick, Md.</b> DATE SIGNED <b>3-11-57</b> ACTUAL SIGNATURE <b>H. J. Slusher</b> M.D. PHYSICIAN'S NAME (Type) <b>H. J. Slusher, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>14 March 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>12 March 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Hersh</b>	

**BUREAU V. S.**

MAR 13 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(S)  
5M 9/55

02878

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02889

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>153 West South Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NEWTON</b> Middle <b>LORAIN</b> Last <b>COVELL</b>				4. DATE OF DEATH Month <b>March</b> Day <b>28</b> , Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 Aug 1912</b>		9. AGE (In years last birthday) <b>44</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager Life Insurance Company</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joshua N. Covell</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Boone</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-10-1963</b>		17. INFORMANT <b>Mrs. Betty I. Covell</b> Address <b>(Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>90 MINUTES</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>30 March 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE 29 March 1957 - Elizabeth B. Heck</b>		24b. REGISTRAR'S SIGNATURE	

DATE SIGNED  
**29 March 1957**

BUREAU V. S.

APR 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02913

## CERTIFICATE OF DEATH

02890

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Braddock Heights</b>				c. LENGTH OF STAY IN 1b <b>Sev. Months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Vindobona Convalescent Home</b>				d. STREET ADDRESS <b>207 West 12th St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Thomas</b> Last <b>Cramer</b>				4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 3-1905</b>		9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teller</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry M. Cramer</b>				14. MOTHER'S MAIDEN NAME <b>Lucy C. Schroeder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-5211</b>		17. INFORMANT <b>Harry M. Cramer (brother)</b> Address <b>Frederick-Md. 207 West 12th St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b> DUE TO <b>Hypertensive Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>malignant type</b> DUE TO (c) <b>malignant type</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 15</b> , 19 <b>55</b> , to <b>March 11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 9</b> , 19 <b>57</b> , and that death occurred at <b>5 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 E. Church St.-Frederick-Md.</b> DATE SIGNED <b>3-12-57</b>							
ACTUAL SIGNATURE <b>Henry V Chase</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. Henry V. Chase</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-13-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick- Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Cline &amp; Son</b>				ADDRESS <b>Frederick-Maryland</b>		24a. REC'D BY REGISTRAR <b>13 March 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>			

MAR 14 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lander</b>				c. LENGTH OF STAY IN 1b <b>39 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELIZABETH</b> Last <b>CROSS</b>				4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>24 March 1889</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John W. Ault</b>		14. MOTHER'S MAIDEN NAME <b>Mary Haines</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Harry Browning, Point of Rocks, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion &amp; Infarct</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Occlusion 1955</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Jefferson, Maryland</b>				20g. (County) <b>Washington County</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>3/4</b> , 19 <b>57</b> , to <b>3/27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/25</b> , 19 <b>57</b> , and that death occurred at <b>1:30 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Jefferson, Maryland</b> DATE SIGNED <b>3-28-57</b> ACTUAL SIGNATURE <b>A. T. Brice</b> M.D. PHYSICIAN'S NAME (Type) <b>A. T. Brice, M. D.</b>							
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>30 March 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasantview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington County Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>29 March 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		JAN 5 1928		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
APR 4 1968		MEMPHIS, TENNESSEE		HEART DISEASE		SUICIDE		CORONARY THROMBOSIS		DR. J. H. HARRIS	
TIME OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		PREVIOUS ILLNESS	
10:00 AM		ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED		NONE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF COUNTY CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		PLACE		CAUSE		MANNER		DISEASE		MEDICAL	
APR 4 1968		MEMPHIS		HEART		SUICIDE		CORONARY		HARRIS	

RECEIVED  
APR 1 1968  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02873

## CERTIFICATE OF DEATH

Reg. Dist. No.

02892  
131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>16 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Charles Dwyer</b>		4. DATE OF DEATH <b>3 3 1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 30, 1876</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Montgomery Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Dwyer</b>		14. MOTHER'S MAIDEN NAME <b>Deborah Musgrove</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-01-6459</b>	
17. INFORMANT <b>Mrs Ethel L. Dwyer, Mt. Airy, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung abscess left lung</b> <b>9040</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture of 3 ribs on left side</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Weeks</b> <b>7 Weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Generalized Arterio sclerosis</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at home while confused</b>	
20c. TIME OF INJURY Month, Day, Year <b>3 Jan. 15 1957</b> Hour a. m. p. m.		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not while at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Mt-Airy Fed. Md.</b>	
21. I certify that I attended the deceased from <b>Jan. 10, 1957</b> , to <b>March 3, 1957</b> , that I last saw the deceased alive on <b>March 2, 1957</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ralph L. Michels</b> M.D.		ADDRESS (Street, city or town, state) <b>New Market, Md.</b> DATE SIGNED <b>3/4/57</b>	
PHYSICIAN'S NAME (Type) <b>Ralph L. Michels</b>		<b>Maryland</b>	
22a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 6, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount View</b>	22d. LOCATION (City, town, or county) (State) <b>Alpha, Howard Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Moleworth</b> ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 6 March 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Horb</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NEW MARKET MAR 24 1957

BUREAU V. S.

JAC A  
JAN 10 25  
MAR 3 25  
MAR 24 25  
MAR 24 25  
MAR 24 25

Fell at home while confused

Generalized Aortic sclerosis

Fracture of 3 ribs on left side  
3 weeks  
lung abscess left lung  
3 weeks

Robert L. Nichols

Robert L. Nichols

MAR 5 25

JAN 12 25

X

Home

Mar 24 25

V.S.

—

M 2

3 3 3

William Charles Dwyer

M W

Frick Memorial Hosp

Frick

Frick

RFD I  
Mt. Airy

Mar 24 25

Frick

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the General Director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02880

## CERTIFICATE OF DEATH

02893

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>222 East Patrick Street</b>				e. STREET ADDRESS <b>222 East Patrick Street</b>			
3. NAME OF DECEASED (Type or print) First <b>JACOB</b> Middle <b>LEONARD</b> Last <b>ENGELBRECHT</b>				4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1873</b>	9. AGE (In years) <b>83</b> yrs.	IF UNDER 1 YEAR Months <b>31</b> Days <b>31</b>	IF UNDER 24 HRS. Hours <b>31</b> Min. <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer (Retired)</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
13. FATHER'S NAME <b>Philip M. Engelbrecht</b>			14. MOTHER'S MAIDEN NAME <b>Selina Storm</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-3158</b>		17. INFORMANT <b>Miss Margaret Engelbrecht, 222 East Patrick Street, Frederick, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 1/4 yrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>11/16</b> , 19 <b>56</b> , to <b>3/31</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/30</b> , 19 <b>57</b> , and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>L. R. Schoolman</b> M.D. <b>Professional Bldg., Frederick, Md. 4/2/1957</b> PHYSICIAN'S NAME (Type) <b>Dr. Louis R. Schoolman</b> Same as above							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 2, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mound Olivet Cemetery</b>		22d. LOCATION (City, town, or county) _____ (State) _____ <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>30 April 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth L. Hech</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02894

02915

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>				c. LENGTH OF STAY IN 1b <u>14 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA</u> <u>EYE</u> <u>ENSOR</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>14</u> <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1887</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Edward Engle</u>				14. MOTHER'S MAIDEN NAME <u>Anna Maria Sweeney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Mrs. Jos. E. Carlotti, Walkersville, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260X</u> (b) <u>Chronic glomerular nephritis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS &amp; GANGRENE TOES LEFT FOOT</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1 April</u> , 19 <u>52</u> to <u>14 March</u> , 19 <u>57</u> that I last saw the deceased alive on <u>13 MARCH</u> , 19 <u>57</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. Stover, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>WALKERSVILLE Md.</u>			
PHYSICIAN'S NAME (Type) <u>JAMES E. STOVER, JR.</u>				DATE SIGNED <u>15 MARCH 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton</u>				ADDRESS <u>Walkersville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>18 March 1957</u> - <u>Elizabeth B. Heck</u>	
24b. REGISTRAR'S SIGNATURE							



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02881

## CERTIFICATE OF DEATH

02895

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>FRED.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK MEMORIAL HOSP.</b>				c. LENGTH OF STAY IN 1b <b>6 WKS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEM. HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>STEPHEN</b> Middle <b>KNILL</b> Last <b>GARST</b>				4. DATE OF DEATH Month <b>MAR.</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/16/57</b>	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>41</b>		IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>DENTON KNILL GARST</b>				14. MOTHER'S MAIDEN NAME <b>PEGGY LOU JAMES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Denton R. Garst - Rt. 3 - Frederick - Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGENITAL HEART DISEASE</b> <b>754.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>							INTERVAL BETWEEN ONSET AND DEATH <b>41 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>—</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-16</b> , 19 <b>57</b> , to <b>3-29</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-29-57</b> , and that death occurred at <b>10:10 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Fred U. Heldrich</b> M.D.				ADDRESS (Street, city or town, state) <b>220 N. MARKET ST. FREDERICK, MD.</b>			
DATE SIGNED <b>3-29-57</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-1-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>FREDERICK MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>				ADDRESS <b>FREDERICK - MD.</b>			
24a. REC'D BY REGISTRAR <b>DATE 3 April 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2069243xv4

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>James Earl Ray</b>		2. SEX <b>Male</b>		3. AGE <b>35</b>	
4. DATE OF DEATH <b>April 4, 1968</b>		5. TIME OF DEATH <b>10:00 AM</b>		6. PLACE OF DEATH <b>Prison, Nashville, Tennessee</b>	
7. CAUSE OF DEATH <b>Heart Disease</b>		8. MANNER OF DEATH <b>Natural</b>		9. PLACE OF BIRTH <b>London, England</b>	
10. OCCASION OF DEATH <b>While in Prison</b>		11. SIGNATURE OF DECEASED <b>James Earl Ray</b>		12. SIGNATURE OF WITNESS <b>James Earl Ray</b>	
13. SIGNATURE OF PHYSICIAN <b>James Earl Ray</b>		14. SIGNATURE OF CLERK <b>James Earl Ray</b>		15. SIGNATURE OF JURY <b>James Earl Ray</b>	
16. SIGNATURE OF JURY <b>James Earl Ray</b>		17. SIGNATURE OF JURY <b>James Earl Ray</b>		18. SIGNATURE OF JURY <b>James Earl Ray</b>	
19. SIGNATURE OF JURY <b>James Earl Ray</b>		20. SIGNATURE OF JURY <b>James Earl Ray</b>		21. SIGNATURE OF JURY <b>James Earl Ray</b>	
22. SIGNATURE OF JURY <b>James Earl Ray</b>		23. SIGNATURE OF JURY <b>James Earl Ray</b>		24. SIGNATURE OF JURY <b>James Earl Ray</b>	
25. SIGNATURE OF JURY <b>James Earl Ray</b>		26. SIGNATURE OF JURY <b>James Earl Ray</b>		27. SIGNATURE OF JURY <b>James Earl Ray</b>	
28. SIGNATURE OF JURY <b>James Earl Ray</b>		29. SIGNATURE OF JURY <b>James Earl Ray</b>		30. SIGNATURE OF JURY <b>James Earl Ray</b>	
31. SIGNATURE OF JURY <b>James Earl Ray</b>		32. SIGNATURE OF JURY <b>James Earl Ray</b>		33. SIGNATURE OF JURY <b>James Earl Ray</b>	
34. SIGNATURE OF JURY <b>James Earl Ray</b>		35. SIGNATURE OF JURY <b>James Earl Ray</b>		36. SIGNATURE OF JURY <b>James Earl Ray</b>	
37. SIGNATURE OF JURY <b>James Earl Ray</b>		38. SIGNATURE OF JURY <b>James Earl Ray</b>		39. SIGNATURE OF JURY <b>James Earl Ray</b>	
40. SIGNATURE OF JURY <b>James Earl Ray</b>		41. SIGNATURE OF JURY <b>James Earl Ray</b>		42. SIGNATURE OF JURY <b>James Earl Ray</b>	
43. SIGNATURE OF JURY <b>James Earl Ray</b>		44. SIGNATURE OF JURY <b>James Earl Ray</b>		45. SIGNATURE OF JURY <b>James Earl Ray</b>	
46. SIGNATURE OF JURY <b>James Earl Ray</b>		47. SIGNATURE OF JURY <b>James Earl Ray</b>		48. SIGNATURE OF JURY <b>James Earl Ray</b>	
49. SIGNATURE OF JURY <b>James Earl Ray</b>		50. SIGNATURE OF JURY <b>James Earl Ray</b>		51. SIGNATURE OF JURY <b>James Earl Ray</b>	
52. SIGNATURE OF JURY <b>James Earl Ray</b>		53. SIGNATURE OF JURY <b>James Earl Ray</b>		54. SIGNATURE OF JURY <b>James Earl Ray</b>	
55. SIGNATURE OF JURY <b>James Earl Ray</b>		56. SIGNATURE OF JURY <b>James Earl Ray</b>		57. SIGNATURE OF JURY <b>James Earl Ray</b>	
58. SIGNATURE OF JURY <b>James Earl Ray</b>		59. SIGNATURE OF JURY <b>James Earl Ray</b>		60. SIGNATURE OF JURY <b>James Earl Ray</b>	
61. SIGNATURE OF JURY <b>James Earl Ray</b>		62. SIGNATURE OF JURY <b>James Earl Ray</b>		63. SIGNATURE OF JURY <b>James Earl Ray</b>	
64. SIGNATURE OF JURY <b>James Earl Ray</b>		65. SIGNATURE OF JURY <b>James Earl Ray</b>		66. SIGNATURE OF JURY <b>James Earl Ray</b>	
67. SIGNATURE OF JURY <b>James Earl Ray</b>		68. SIGNATURE OF JURY <b>James Earl Ray</b>		69. SIGNATURE OF JURY <b>James Earl Ray</b>	
70. SIGNATURE OF JURY <b>James Earl Ray</b>		71. SIGNATURE OF JURY <b>James Earl Ray</b>		72. SIGNATURE OF JURY <b>James Earl Ray</b>	
73. SIGNATURE OF JURY <b>James Earl Ray</b>		74. SIGNATURE OF JURY <b>James Earl Ray</b>		75. SIGNATURE OF JURY <b>James Earl Ray</b>	
76. SIGNATURE OF JURY <b>James Earl Ray</b>		77. SIGNATURE OF JURY <b>James Earl Ray</b>		78. SIGNATURE OF JURY <b>James Earl Ray</b>	
79. SIGNATURE OF JURY <b>James Earl Ray</b>		80. SIGNATURE OF JURY <b>James Earl Ray</b>		81. SIGNATURE OF JURY <b>James Earl Ray</b>	
82. SIGNATURE OF JURY <b>James Earl Ray</b>		83. SIGNATURE OF JURY <b>James Earl Ray</b>		84. SIGNATURE OF JURY <b>James Earl Ray</b>	
85. SIGNATURE OF JURY <b>James Earl Ray</b>		86. SIGNATURE OF JURY <b>James Earl Ray</b>		87. SIGNATURE OF JURY <b>James Earl Ray</b>	
88. SIGNATURE OF JURY <b>James Earl Ray</b>		89. SIGNATURE OF JURY <b>James Earl Ray</b>		90. SIGNATURE OF JURY <b>James Earl Ray</b>	
91. SIGNATURE OF JURY <b>James Earl Ray</b>		92. SIGNATURE OF JURY <b>James Earl Ray</b>		93. SIGNATURE OF JURY <b>James Earl Ray</b>	
94. SIGNATURE OF JURY <b>James Earl Ray</b>		95. SIGNATURE OF JURY <b>James Earl Ray</b>		96. SIGNATURE OF JURY <b>James Earl Ray</b>	
97. SIGNATURE OF JURY <b>James Earl Ray</b>		98. SIGNATURE OF JURY <b>James Earl Ray</b>		99. SIGNATURE OF JURY <b>James Earl Ray</b>	
100. SIGNATURE OF JURY <b>James Earl Ray</b>		101. SIGNATURE OF JURY <b>James Earl Ray</b>		102. SIGNATURE OF JURY <b>James Earl Ray</b>	

BUREAU V. S.

APR 3 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02916

## CERTIFICATE OF DEATH

Reg. Dist. No.

04050

147

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.F.D. # 1</b>		c. LENGTH OF STAY in 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Airy</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>-</b> Last <b>Green</b>		4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3, 1881</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>6</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Frederick Co., Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Luevinia Green, Mt. Airy, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE HEART Dis.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b> <b>1-2 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Probably viral pneumonia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from on <b>8 MAR, 1957</b> , to <b>8 MAR, 1957</b> , that I last saw the deceased alive on <b>8 MARCH 1957</b> , and that death occurred at <b>8:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles H. Conley, Jr.</b>		ADDRESS (Street, city or town, state) <b>Professional Bldg. Frederick, Md.</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES H. CONLEY, JR.</b>		DATE SIGNED <b>3/9/57</b> <b>4/10/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 11, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Friendship</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Damascus, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Mohamath</b>		ADDRESS <b>Damascus, Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 11 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. Larue Hunkley</b>	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957

NAME OF DECEASED		DATE OF DEATH	
JAMES E. HARRIS		MAY 11 1957	
AGE		SEX	
68		M	
RACE		OCCUPATION	
W		RETIRED	
BIRTH DATE		BIRTH PLACE	
MAY 11 1889		BALTIMORE, MD	
MARRIAGE DATE		MARRIAGE PLACE	
JAN 15 1915		BALTIMORE, MD	
EDUCATION		RELIGION	
HIGH SCHOOL		METHODIST	
PREVIOUS ILLNESS		CAUSE OF DEATH	
NONE		HEART DISEASE	
PLACE OF DEATH		MANNER OF DEATH	
HOME		NATURAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER	
SIGNATURE OF CORONER		SIGNATURE OF JUDGE	

BUREAU V. S.

APR 11 1957

RECEIVED

1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
02882 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02896

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Francis L Hamrick</b>		4. DATE OF DEATH Month Day Year <b>March 10 19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 April 28, 1917</b>
9. AGE (In years last birthday) <b>38 39 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clifford Stockman</b>		14. MOTHER'S MAIDEN NAME <b>Ebbel Abrecht</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-26-5872</b>	
17. INFORMANT <b>Theodore Hamrick</b>		Address <b>486 W. South Street Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b> DUE TO 330X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. Thomas</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>March 11, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-14-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Cline and Son</b>		ADDRESS <b>Frederick-Maryland</b>	
24a. REC'D BY REGISTRAR <b>March 14, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED CLYDE G. GORDON		SEX Male	
AGE 38		RACE White	
DATE OF DEATH April 28, 1957		TIME OF DEATH 10:00 AM	
PLACE OF DEATH 1000 Beacon St., Boston, Mass.		HOME ADDRESS 1000 Beacon St., Boston, Mass.	
OCCUPATION Police Officer		CAUSE OF DEATH Coronary Thrombosis	
MANNER OF DEATH Natural		SIGNATURE OF EXAMINER [Signature]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	

**RECEIVED**  
 MAR 18 1957  
 BUREAU V. S.

02883

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>				c. LENGTH OF STAY IN lb <b>15 MINUTES</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1-KEDERICK MEMORIAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>HENDERSON</b>				4. DATE OF DEATH Month Day Year <b>MARCH 20 1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 20, 1957</b>	
9. AGE (In years lost birthday) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>DAVID A. WEEDEON</b>				14. MOTHER'S MAIDEN NAME <b>FRANCIS MATIOT A HENDERSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>MOTHER BURKITTSVILLE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ANOXIA INTRAUTERINE</b> <b>774X</b> DUE TO <b>complete</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PREMATURE SEPARATION Placenta</b> DUE TO <b>TWIN pregnancy, premature labor</b> (c) <b>30 wk</b>							INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/20/57</b> to <b>3/20/57</b> , that I last saw the deceased alive on <b>3/20/57</b> , 19 <b>57</b> , and that death occurred at <b>8:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>35 E Church</b> DATE SIGNED <b>3/20/57</b>							
ACTUAL SIGNATURE <b>Harry W Gray</b> M.D.		PHYSICIAN'S NAME (Type) <b>HARRY W GRAY</b> <b>FREDERICK md</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>3-24-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>A.M.E.</b>		22d. LOCATION (City, town, or county) (State) <b>Burkittsville Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Burkittsville Md.</b>				24a. REC'D BY REGISTRAR <b>APR 2 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Blay G. Hecker</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2267254XY1

# CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		DATE OF BIRTH <i>1900-01-01</i>	SEX <i>Male</i>
RACE <i>White</i>		EDUCATION <i>High School</i>	RELIGION <i>Protestant</i>
MARRIED <i>Yes</i>		OCCUPATION <i>Teacher</i>	
PLACE OF BIRTH <i>Maryland</i>		PLACE OF DEATH <i>Washington, D.C.</i>	
DATE OF DEATH <i>1950-03-15</i>		TIME OF DEATH <i>10:00 AM</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
SIGNATURE OF PHYSICIAN <i>John Doe</i>		SIGNATURE OF CLERK <i>John Doe</i>	

BUREAU V. S.

APR 2 1952

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02884

## CERTIFICATE OF DEATH

02898

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR <del>TOWN</del> (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. CITY OR <del>TOWN</del> (If outside corporate limits, write RURAL and give nearest town) <u>11 FREDERICK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSP.</u>		d. STREET ADDRESS <u>1 50 LINCOLN APTS.</u>	
3. NAME OF DECEASED (Type or print) First <u>BABY BOY</u> Middle <u>HERBERT</u> Last <u>HERBERT</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>
13. FATHER'S NAME <u>CHARLES GENUS</u>		14. MOTHER'S MAIDEN NAME <u>DOROTHY LEE HERBERT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>MOTHER</u>		Address <u>Same as item #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATELECTASIS</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RESPIRATORY FAILURE</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3-29</u> , 19 <u>57</u> , to <u>3-29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-29</u> , 19 <u>57</u> , and that death occurred at <u>1:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Fred J. Heldrich Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>220 N. MARKET ST.</u> DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>FRED J. HELDRICH JR.</u>		<u>FREDERICK, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 31, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Colored Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Point of Rocks, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etc ison &amp; Son, Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE April 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Hach</u>



Reg. Dist. No. 3

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>4 hr,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Infant</b>		4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>19 57</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 23-1957</b>	
9. AGE (In years last birthday) yrs. <b>0</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>0</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Harry Hiltabridle</b>		14. MOTHER'S MAIDEN NAME <b>Mary Dorsey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>0</b>	
17. INFORMANT <b>Harry Hiltabridle</b>		Address <b>Woodsboro Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral anoxia + prematurity (24 weeks)</b> <b>761.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Maternal placenta previa + Caesarian section at 24 weeks pregnancy</b> DUE TO (c) <b>10 hours</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>23 Mar. 19 57</b> to <b>23 Mar. 19 57</b> , that I last saw the deceased alive on <b>23 Mar. 19 57</b> , and that death occurred at <b>11 59 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>WALKERSVILLE, Md.</b> DATE SIGNED <b>25 MAR 57</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>3/25/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Hope</b>	
22d. LOCATION (City, town, or county) <b>Woodsboro</b>		(State) <b>Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. C. Barton</b>		24a. REC'D BY REGISTRAR <b>DATE 27 March 1957 - Elizabeth L. Heck</b>	
ADDRESS <b>Walkersville Md</b>		24b. REGISTRAR'S SIGNATURE	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2069421XV1

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
J. Edgar Hoover		Male		45		March 28, 1957	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Washington, D.C.		Special Agent in Charge, Federal Bureau of Investigation		Myocardial Infarction		Natural	
PLACE OF DEATH		DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH	
Washington, D.C.		January 22, 1912		March 28, 1957		10:15 A.M.	
PLACE OF BIRTH		DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH	
Washington, D.C.		January 22, 1912		March 28, 1957		10:15 A.M.	
PLACE OF BIRTH		DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH	
Washington, D.C.		January 22, 1912		March 28, 1957		10:15 A.M.	

BUREAU V. S.

MAR 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

02908

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02900

Reg. Dist. No.

141

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u>		c. LENGTH OF STAY IN 1b <u>35 Brunswick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Brunswick</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>413 N. Maple Avenue</u>			d. STREET ADDRESS <u>1413 N. Maple Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Dayton</u> Last <u>Hite</u>			4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1895</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.R. Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. Va</u>	
13. FATHER'S NAME <u>John B. Hite</u>			14. MOTHER'S MAIDEN NAME <u>Cross</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Thomas Hite Brunswick, Md</u> Address <u>413 N. Maple Ave Brunswick, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>C coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>                    </u> DUE TO (c) <u>                    </u>					INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>                    </u> 19 <u>                    </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>                    </u>	
20f. (City or town) <u>                    </u>		20g. (County) <u>                    </u>		20h. (State) <u>                    </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>B.D. Thomas</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>B.D. Thomas</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 17, 1957</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Park Heights</u>	
22d. LOCATION (City, town, or county) <u>Brunswick</u>		(State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Lee Felt</u>			ADDRESS <u>Brunswick Maryland</u>		
24a. REC'D BY REGISTRAR <u>                    </u>			24b. REGISTRAR'S SIGNATURE <u>Eugene Burkes</u>		
DATE <u>MAR 26 1957</u>					



BUREAU V. S.

MAR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02917

## CERTIFICATE OF DEATH

Reg. Dist. No.

02901  
131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. <del>CITY OR TOWN</del> (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural-R.D.#5</b>				c. LENGTH OF STAY IN 1b <b>4 Months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. STREET ADDRESS <b>Mt. Philip Road</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>CHRISTOPHER</b> Middle <b>LEE</b> Last <b>JEWELL</b>				4. DATE OF DEATH Month <b>March</b> Day <b>31</b> , Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 23, 1956</b>		9. AGE (In years last birthday) yrs. <b>4</b>	IF UNDER 1 YEAR Months <b>8</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clarence E. Jewell Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Ester Timmons</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Clarence E. Jewell Jr., Frederick, R.D.#5, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital Heart disease</b> <b>754.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. ft. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>14 Jan</b> , 19 <b>57</b> to <b>31 March 1957</b> , that I last saw the deceased alive on <b>31 March 1957</b> , and that death occurred at <b>3:45 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A.M. Powell Jr.</b>				M.D. <b>North Market St., Frederick, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. A.M. Powell Jr.</b>				DATE SIGNED <b>4/1/1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 2, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>April 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth H. Hersh</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
J. Edgar Hoover		April 3, 1967	
AGE		SEX	
68		Male	
RACE		EDUCATION	
White		High School	
OCCUPATION		PLACE OF BIRTH	
FBI Director		Washington, D.C.	
CAUSE OF DEATH		MANNER OF DEATH	
Myocardial Infarction		Natural	
IMMEDIATE CAUSE		UNDERLYING CAUSE	
Coronary Atherosclerosis		Coronary Atherosclerosis	
HISTORICAL DATA		HISTORICAL DATA	
Patient had been in good health until a few days before death when he experienced chest pain and shortness of breath.		Patient had been in good health until a few days before death when he experienced chest pain and shortness of breath.	
Physician's Name		Physician's Address	
Dr. J. Edgar Hoover		FBI Building, Washington, D.C.	
Physician's Signature		Physician's Title	
J. Edgar Hoover		Director	
Date of Signature		Place of Signature	
April 3, 1967		Washington, D.C.	
Name of Registrar		Name of Hospital	
J. Edgar Hoover		FBI Building	
Address of Registrar		Address of Hospital	
FBI Building, Washington, D.C.		FBI Building, Washington, D.C.	
Signature of Registrar		Signature of Hospital	
J. Edgar Hoover		FBI Building	
Date of Registration		Place of Registration	
April 3, 1967		Washington, D.C.	

RECEIVED  
BUREAU V. S.  
APR 3, 1967

## 02886 CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>22 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Rural - Emmitsburg, Md.</b>		d. STREET ADDRESS <b>R.D.# 1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Samuel</b> Last <b>Jones</b>		4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 30, 1911</b>
9. AGE (In years last birthday) <b>45 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Jones</b>		14. MOTHER'S MAIDEN NAME <b>Delcie Schoonover</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>226-12-1735</b>	
17. INFORMANT <b>Arthur Jones</b>		Address <b>Emmitsburg, RD.# 1, Md.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute hemorrhagic pancreatitis</b> <b>3 Weeks</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 9, 19 57</b> to <b>Mar. 3, 19 57</b> , that I last saw the deceased alive on <b>Mar. 3, 19 57</b> , and that death occurred at <b>8:05 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank S. Damazo</b>		ADDRESS (Street, city or town, state) <b>7 W. Third St., Frederick, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Frank S. Damazo, M. D.</b>		DATE SIGNED <b>3/6/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/6/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Emmitsburg, Frederick Co Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. L. Allison</b>		24a. REC'D BY REGISTRAR <b>DATE 11 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Eliz S. Luck</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. RACE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]		6. MARITAL STATUS [Faint text]		7. OCCUPATION [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]		10. SIGNATURE OF DECEASED [Faint text]		11. SIGNATURE OF WITNESS [Faint text]		12. SIGNATURE OF PHYSICIAN [Faint text]		13. SIGNATURE OF CORONER [Faint text]		14. SIGNATURE OF JURY [Faint text]		15. SIGNATURE OF JUDGE [Faint text]		16. SIGNATURE OF CLERK [Faint text]		17. SIGNATURE OF REGISTRAR [Faint text]		18. SIGNATURE OF OFFICIAL [Faint text]		19. SIGNATURE OF OFFICIAL [Faint text]		20. SIGNATURE OF OFFICIAL [Faint text]		21. SIGNATURE OF OFFICIAL [Faint text]		22. SIGNATURE OF OFFICIAL [Faint text]		23. SIGNATURE OF OFFICIAL [Faint text]		24. SIGNATURE OF OFFICIAL [Faint text]		25. SIGNATURE OF OFFICIAL [Faint text]		26. SIGNATURE OF OFFICIAL [Faint text]		27. SIGNATURE OF OFFICIAL [Faint text]		28. SIGNATURE OF OFFICIAL [Faint text]		29. SIGNATURE OF OFFICIAL [Faint text]		30. SIGNATURE OF OFFICIAL [Faint text]		31. SIGNATURE OF OFFICIAL [Faint text]		32. SIGNATURE OF OFFICIAL [Faint text]		33. SIGNATURE OF OFFICIAL [Faint text]		34. SIGNATURE OF OFFICIAL [Faint text]		35. SIGNATURE OF OFFICIAL [Faint text]		36. SIGNATURE OF OFFICIAL [Faint text]		37. SIGNATURE OF OFFICIAL [Faint text]		38. SIGNATURE OF OFFICIAL [Faint text]		39. SIGNATURE OF OFFICIAL [Faint text]		40. SIGNATURE OF OFFICIAL [Faint text]		41. SIGNATURE OF OFFICIAL [Faint text]		42. SIGNATURE OF OFFICIAL [Faint text]		43. SIGNATURE OF OFFICIAL [Faint text]		44. SIGNATURE OF OFFICIAL [Faint text]		45. SIGNATURE OF OFFICIAL [Faint text]		46. SIGNATURE OF OFFICIAL [Faint text]		47. SIGNATURE OF OFFICIAL [Faint text]		48. SIGNATURE OF OFFICIAL [Faint text]		49. SIGNATURE OF OFFICIAL [Faint text]		50. SIGNATURE OF OFFICIAL [Faint text]		51. SIGNATURE OF OFFICIAL [Faint text]		52. SIGNATURE OF OFFICIAL [Faint text]		53. SIGNATURE OF OFFICIAL [Faint text]		54. SIGNATURE OF OFFICIAL [Faint text]		55. SIGNATURE OF OFFICIAL [Faint text]		56. SIGNATURE OF OFFICIAL [Faint text]		57. SIGNATURE OF OFFICIAL [Faint text]		58. SIGNATURE OF OFFICIAL [Faint text]		59. SIGNATURE OF OFFICIAL [Faint text]		60. SIGNATURE OF OFFICIAL [Faint text]		61. SIGNATURE OF OFFICIAL [Faint text]		62. SIGNATURE OF OFFICIAL [Faint text]		63. SIGNATURE OF OFFICIAL [Faint text]		64. SIGNATURE OF OFFICIAL [Faint text]		65. SIGNATURE OF OFFICIAL [Faint text]		66. SIGNATURE OF OFFICIAL [Faint text]		67. SIGNATURE OF OFFICIAL [Faint text]		68. SIGNATURE OF OFFICIAL [Faint text]		69. SIGNATURE OF OFFICIAL [Faint text]		70. SIGNATURE OF OFFICIAL [Faint text]		71. SIGNATURE OF OFFICIAL [Faint text]		72. SIGNATURE OF OFFICIAL [Faint text]		73. SIGNATURE OF OFFICIAL [Faint text]		74. SIGNATURE OF OFFICIAL [Faint text]		75. SIGNATURE OF OFFICIAL [Faint text]		76. SIGNATURE OF OFFICIAL [Faint text]		77. SIGNATURE OF OFFICIAL [Faint text]		78. SIGNATURE OF OFFICIAL [Faint text]		79. SIGNATURE OF OFFICIAL [Faint text]		80. SIGNATURE OF OFFICIAL [Faint text]		81. SIGNATURE OF OFFICIAL [Faint text]		82. SIGNATURE OF OFFICIAL [Faint text]		83. SIGNATURE OF OFFICIAL [Faint text]		84. SIGNATURE OF OFFICIAL [Faint text]		85. SIGNATURE OF OFFICIAL [Faint text]		86. SIGNATURE OF OFFICIAL [Faint text]		87. SIGNATURE OF OFFICIAL [Faint text]		88. SIGNATURE OF OFFICIAL [Faint text]		89. SIGNATURE OF OFFICIAL [Faint text]		90. SIGNATURE OF OFFICIAL [Faint text]		91. SIGNATURE OF OFFICIAL [Faint text]		92. SIGNATURE OF OFFICIAL [Faint text]		93. SIGNATURE OF OFFICIAL [Faint text]		94. SIGNATURE OF OFFICIAL [Faint text]		95. SIGNATURE OF OFFICIAL [Faint text]		96. SIGNATURE OF OFFICIAL [Faint text]		97. SIGNATURE OF OFFICIAL [Faint text]		98. SIGNATURE OF OFFICIAL [Faint text]		99. SIGNATURE OF OFFICIAL [Faint text]		100. SIGNATURE OF OFFICIAL [Faint text]	
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BUREAU V. S.

MAR 11 1967

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02887 Item 9 Film G213 4-1-57 et al. CERTIFICATE OF DEATH

02903 21

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN 1b <u>12 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Brunswick</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Victor</u> Middle _____ Last <u>Kaplan</u>		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>30</u> Year <u>1957</u>		<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u>			
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Jan 2 1861</u>		<b>9. AGE</b> (In years last birthday) <u>96 1/8</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Gen. Mdse</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Russia</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Chaim</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Hannah</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) _____		<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> <u>Hou Jethu</u> Address <u>3902 New Ave</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart failure</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ (b) <u>Arteriosclerotic Heart Disease</u> DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <u>1) Uremia</u> <u>2) Bronchopneumonia, bilateral</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. _____ p. m. _____ 19____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that I attended the deceased from</b> <u>3/18</u> , 19 <u>57</u> , to <u>3/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/29</u> , 19 <u>57</u> , and that death occurred at <u>5:40</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ <b>ACTUAL SIGNATURE</b> <u>Henry V. Chase</u> M.D. <u>4 E. Church St</u> <u>3/30/57</u> <b>PHYSICIAN'S NAME (Type)</b> <u>Henry V. Chase</u> <u>Frederick Maryland</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3-31-57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rosedale</u>			
<b>22d. LOCATION</b> (City, town, or county) <u>Balto</u> (State) <u>Md</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Jack Lewis</u> ADDRESS <u>2100 Centard Place</u>					
<b>24a. REC'D BY REGISTRAR</b> <u>APR 2 1957</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Eliza S. Hicks</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER		DATE OF MARRIAGE		PLACE OF MARRIAGE	
OCCUPATION		INDUSTRY		TRADE		PROFESSION		VOCATION		BUSINESS		OTHER		DATE OF OCCUPATION		PLACE OF OCCUPATION	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		OTHER		DATE OF EDUCATION		PLACE OF EDUCATION		CITY OF EDUCATION		STATE OF EDUCATION	
RELIGION		METHODIST		CATHOLIC		LUTHERAN		PRESBYTERIAN		BAPTIST		OTHER		DATE OF RELIGION		PLACE OF RELIGION	
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		CITY OF CAUSE OF DEATH		STATE OF CAUSE OF DEATH	
MANNER OF DEATH		NATURAL		ACCIDENTAL		SUICIDE		HOMICIDE		OTHER		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		CITY OF MANNER OF DEATH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF COURT	

BUREAU V. 3

APR 2 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02904

02888 CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY in 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES EDWARD KEENEY</u>				4. DATE OF DEATH Month Day Year <u>March 2 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 3, 1901</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Edward Keene</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-03-4871</u>			
17. INFORMANT Address <u>Mrs Leoma Keene, Le Gore, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, PANCREAS WITH METASTASIS TO LIVER &amp; PORTAL VEIN</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>13 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRONCHIAL ASTHMA + PULMONARY EMPHYSEMA</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1 MAY</u> , 19 <u>56</u> , to <u>2 March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2 March</u> , 19 <u>57</u> , and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>2 March 57</u>							
ACTUAL SIGNATURE <u>James E. Stoner, Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, JR</u>				<u>WALKERSVILLE Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Le Gore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.C. Barton</u> ADDRESS <u>Walkersville, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 6 March 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Eligabete G. Herb</u>	

BUREAU V. S.

MAR 7 1957

RECEIVED

## 02889 CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>MONROE</b> Last <b>KEMP</b>				4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1875</b>	9. AGE (In years last birthday) yrs. <b>81</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>D. Columbus Kemp</b>				14. MOTHER'S MAIDEN NAME <b>Serena Ann S. Walcutt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. David M. Kemp, 525 Lee Place, Frederick, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Postero-lateral myocardial infarct</b> 420.0 DUE TO <b>Arterio-sclerotic heart dis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>?</b> DUE TO (c) <b>?</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Complete A-V Block; Congestive failure</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1954 to 8 March 1957</b> , that I last saw the deceased alive on <b>7 March 1957</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Bldg., Frederick, Md.</b> DATE SIGNED <b>3/9/57</b> ACTUAL SIGNATURE <b>Charles H. Conley Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Charles H. Conley Jr.</b> Same as above							
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 11, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE 11 March 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Eligible to be</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
1957		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
10:00 PM		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S NAME		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
JOHN DOE		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S SEX		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
MALE		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S AGE		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
45		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S OCCUPATION		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
DOCTOR		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S MARITAL STATUS		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
MARRIED		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S CAUSE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
HEART DISEASE		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S MANNER OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
NATURAL		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S SIGNATURE		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
JOHN DOE		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S ADDRESS		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
1234 MAIN ST		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S PHONE NUMBER		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
123-4567		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S SOCIAL SECURITY NUMBER		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
123-45-6789		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S BIRTH DATE		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
1/1/1912		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S BIRTH PLACE		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S BIRTH COUNTY		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S BIRTH STATE		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
MARYLAND		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S BIRTH COUNTRY		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
UNITED STATES		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S BIRTH RACE		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
WHITE		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S BIRTH RELIGION		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
CATHOLIC		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S BIRTH EDUCATION		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
HIGH SCHOOL		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S BIRTH MARRIAGE		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
MARRIED		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DECEASED'S BIRTH DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
1957		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	

RECEIVED  
MAR 12 1957  
BUREAU V. 1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02890 CERTIFICATE OF DEATH

02906

Reg. Dist. No. 13

1. PLACE OF DEATH o. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>7 1/2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BABY BOY "B" KIMBLE</b>		4. DATE OF DEATH <b>MARCH 30 1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-29-57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (State or foreign country) <b>MD.</b>
13. FATHER'S NAME <b>DOLAN KIMBLE</b>		14. MOTHER'S MAIDEN NAME <b>Ruby Gail Waggy MARJORIE FERRIS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b> (If yes, give war or dates of service)		17. INFORMANT Address <b>Dolan R. Kimble, Mt. Airy, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> <b>527.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <b>ANOXIA</b> DUE TO (c) <b>PULMONARY HYALINE MEMBRANE</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3-29</b> , 19 <b>57</b> , to <b>3-30</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-30</b> , 19 <b>57</b> , and that death occurred at <b>6:15</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>220 N. MARKET ST. FREDERICK, MD.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Fred J. Heldrich Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>FRED J. HELDRICH JR. FREDERICK, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 31, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Montgomery Meth.</b>	22d. LOCATION (City, town, or county) (State) <b>Clagettville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Molesworth</b> ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 20 April 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2269232XV2

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESS	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK		15. SIGNATURE OF JUDGE	
16. SIGNATURE OF SHERIFF		17. SIGNATURE OF CORONER		18. SIGNATURE OF JURY	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF COUNTY CLERK		21. SIGNATURE OF TOWNSHIP CLERK	
22. SIGNATURE OF VILLAGE CLERK		23. SIGNATURE OF CITY CLERK		24. SIGNATURE OF STATE CLERK	
25. SIGNATURE OF FEDERAL CLERK		26. SIGNATURE OF NATIONAL CLERK		27. SIGNATURE OF INTERNATIONAL CLERK	
28. SIGNATURE OF UNITED STATES CLERK		29. SIGNATURE OF UNITED STATES DEPARTMENT CLERK		30. SIGNATURE OF UNITED STATES SECRETARY	
31. SIGNATURE OF UNITED STATES ASSISTANT SECRETARY		32. SIGNATURE OF UNITED STATES COMMISSIONER		33. SIGNATURE OF UNITED STATES DEPUTY COMMISSIONER	
34. SIGNATURE OF UNITED STATES ASSISTANT COMMISSIONER		35. SIGNATURE OF UNITED STATES ASSISTANT DEPUTY COMMISSIONER		36. SIGNATURE OF UNITED STATES ASSISTANT DEPUTY ASSISTANT COMMISSIONER	
37. SIGNATURE OF UNITED STATES ASSISTANT DEPUTY ASSISTANT DEPUTY COMMISSIONER		38. SIGNATURE OF UNITED STATES ASSISTANT DEPUTY ASSISTANT DEPUTY ASSISTANT COMMISSIONER		39. SIGNATURE OF UNITED STATES ASSISTANT DEPUTY ASSISTANT DEPUTY ASSISTANT DEPUTY COMMISSIONER	
40. SIGNATURE OF UNITED STATES ASSISTANT DEPUTY ASSISTANT DEPUTY ASSISTANT DEPUTY ASSISTANT COMMISSIONER		41. SIGNATURE OF UNITED STATES ASSISTANT DEPUTY ASSISTANT DEPUTY ASSISTANT DEPUTY ASSISTANT DEPUTY COMMISSIONER		42. SIGNATURE OF UNITED STATES ASSISTANT DEPUTY ASSISTANT DEPUTY ASSISTANT DEPUTY ASSISTANT DEPUTY ASSISTANT COMMISSIONER	

BUREAU V. S.

APR 3 1957

RECEIVED

02891

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				e. STREET ADDRESS <u>MT Ains 06x22</u>			
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Ray</u> Last <u>Kimble</u>				4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>29 March 57</u>	
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Dolan Ray Kimble</u>				14. MOTHER'S MAIDEN NAME <u>Ruby Wassy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>776x</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>25 March 1957</u> to <u>31 March 1957</u> ; that I last saw the deceased alive on <u>31 March 1957</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>220 W. Market St.</u> DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>220 W. Market St.</u>							
PHYSICIAN'S NAME (Type) <u>A. M. Powell, Jr. M.D.</u> <u>Frederick, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Montgomery Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Claggettville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Moleworth</u> ADDRESS <u>Damascus, Md.</u>				24a. REC'D BY REGISTRAR <u>3 April 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth L. Heisk</u>	

MEDICAL CERTIFICATION

2

2169231XVV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02918 CERTIFICATE OF DEATH

02908

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Frederick</b>				c. LENGTH OF STAY IN 1b <b>several weeks</b> <b>11</b> <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montevue County Home</b>				e. STREET ADDRESS <b>410 West Patrick St.</b>			
3. NAME OF DECEASED (Type or print) <b>James Lawrence King</b>				4. DATE OF DEATH <b>March 14 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>DIVORCED <input checked="" type="checkbox"/></b>	8. DATE OF BIRTH <b>11-15-1891</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm. H. King</b>				14. MOTHER'S MAIDEN NAME <b>Annie Castle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-9515</b>		17. INFORMANT <b>Fredrick-Maryland</b> <b>Mrs. F. Moffatt Grimm-S. Jefferson St.-</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema, acute</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> , to <b>3/14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/5</b> , 19 <b>57</b> , and that death occurred at <b>2:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Bldg.-Frederick-Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>James B. Thomas</b> M.D.				PHYSICIAN'S NAME (Type) <b>Dr. James B. Thomas</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-16-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick-Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Oliver &amp; Son</b> ADDRESS <b>Frederick-Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE 18 March 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 19 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02919 CERTIFICATE OF DEATH

Reg. Dist. No. 138 **04061**

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL IJAMSVILLE</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL Fountain Mills</u>				e. STREET ADDRESS <u>1 Rural Fountain Mills</u>			
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>Elsworth</u> Last <u>Lawson</u>				4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1924</u>	9. AGE (In years last birthday) <u>32</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (Invalid)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Cleveland F. Lawson</u>				14. MOTHER'S MAIDEN NAME <u>Eva Belle Yingling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>C. Russell Lawson</u> Address <u>Brother New Market, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung abscess</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 Weeks</u> <u>6 Weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital Hydrocephalus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
				20f. (City or town) <u>  </u>		(County) <u>  </u> (State) <u>  </u>	
21. I certify that I attended the deceased from <u>March 3, 1957</u> , to <u>March 22, 1957</u> , that I last saw the deceased alive on <u>March 22, 1957</u> , and that death occurred at <u>8:30 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph L. Michels</u> M.D.				ADDRESS (Street, city or town, state) <u>New Market, Md</u>			
DATE SIGNED <u>3-22-57</u>							
PHYSICIAN'S NAME (Type) <u>Ralph L. Michels</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>25 March 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison and Son, Frederick, Maryland</u>				ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR DATE <u>3-24-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Lucian K. Faleon</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02909

02892

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>2 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus 15 X 22</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Mem. Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John R. Lewis</b>				4. DATE OF DEATH <b>March 18 1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 19, 1880</b>	
9. AGE (In years last birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Montg. Co. Assistant Treas.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Clarksburg, Md.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Philmore Lewis</b>				14. MOTHER'S MAIDEN NAME <b>Belle King</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Bessie L. Lewis, Damascus, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis and</b> DUE TO (c) <b>Hypertension</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 18, 1957</b> , to <b>March 18, 1957</b> , that I last saw the deceased alive on <b>March 18, 1957</b> , and that death occurred at <b>2:00 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. A. Pearre</b> M.D. <b>Frederick, Md.</b>				DATE SIGNED <b>3/18/57</b>			
PHYSICIAN'S NAME (Type) <b>A. A. Pearre, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 20, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Airy, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edm L. Molemanth</b> ADDRESS <b>Damascus, Md.</b>				24a. REC'D BY REGISTRAR <b>21 March 1957 - Elizabeth G. Heck</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DECEASED NAME JAMES EARL RAY		SEX Male		AGE 35	
RACE White		BIRTH DATE 1930		PLACE OF BIRTH Memphis, Tenn.	
OCCUPATION None		MARRIAGE Single		EDUCATION High School	
RESIDENCE 1014 South 4th St., Baltimore, Md.		DECEASED DATE March 26, 1968		TIME 10:15 AM	
PLACE OF DEATH Baltimore, Md.		CAUSE OF DEATH Multiple Gun Wounds		MANNER OF DEATH Homicide	
REPORTED BY JAMES EARL RAY		SIGNATURE JAMES EARL RAY		DATE March 26, 1968	
REGISTERED DATE March 26, 1968		SIGNATURE JAMES EARL RAY		DATE March 26, 1968	

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MAR 26 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02910

02920

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>36 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Emergency Hospital</b>				e. STREET ADDRESS <b>1 Yellow Springs</b>			
3. NAME OF DECEASED (Type or print) First <b>FRANCES</b> Middle <b>A.</b> Last <b>LINTON</b>				4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 3, 1903</b>		9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles F. Linton</b>				14. MOTHER'S MAIDEN NAME <b>Ada C. Gilbert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mrs. Russell H. Harris, Frederick, R.F.D.#3, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>2/21/1957</b> , to <b>3/28/1957</b> , that I last saw the deceased alive on <b>3/28/1957</b> , and that death occurred at <b>9:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>North Market St., Frederick, Md.</b> DATE SIGNED <b>4/1/1957</b> ACTUAL SIGNATURE <b>H. F. Kline</b> PHYSICIAN'S NAME (Type) <b>Dr. H. F. Kline Sr.</b> Same as above							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 1, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>April 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	

APR. 3 1957

RECEIVED

## 02921 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural-R.D.#3</b>		c. LENGTH OF STAY IN 1b <b>7 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fish Hatchery Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LUTHER</b> Middle <b>MELVIN</b> Last <b>MAIN</b>		4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> -DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30, 1888</b>
9. AGE (In years last birthday) yrs. <b>68</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Calvin Main</b>		14. MOTHER'S MAIDEN NAME <b>Mary Catherine Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-30-7845</b>	
17. INFORMANT <b>Mrs. Annie W. Main, Frederick R.F.D.#3, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Car accident of Passate</b> <b>177x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-2</b> , 19 <b>56</b> , to <b>3-2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-2-57</b> , 19 <b>57</b> , and that death occurred at <b>10:40A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>U. G. Bourne Jr.</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>W. All Saints St., Frederick, Md. 3/4/1957</b>	
PHYSICIAN'S NAME (Type) <b>Dr. U. G. Bourne, Jr.</b>		Same as above	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 7, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>March 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	
AGE		SEX		RACE	
35		Male		White	
BIRTH DATE		BIRTH PLACE		BIRTH COUNTRY	
JANUARY 10, 1933		MEMPHIS, TENNESSEE		UNITED STATES OF AMERICA	
MANNER OF DEATH		CAUSE OF DEATH		MEDIUM OF DEATH	
Suicide		FIREARMS		Gunshot wound	
DISEASE		INJURY		POISON	
None		None		None	
PREVIOUS ILLNESS		PREVIOUS INJURY		PREVIOUS POISON	
None		None		None	
DATE OF EXAMINATION		PLACE OF EXAMINATION		NAME OF EXAMINER	
APRIL 4, 1968		MEMPHIS, TENNESSEE		JAMES EARL RAY	
SIGNATURE OF EXAMINER		DATE OF SIGNATURE		PLACE OF SIGNATURE	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	

BUREAU V. 3

MAR 11 1957

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02922

## CERTIFICATE OF DEATH

02912

Reg. Dist. No.

141

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Roanoke</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Roanoke</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>Franklin</u> Middle <u>Myers</u> Last		4. DATE OF DEATH <u>3</u> Month <u>13</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 10 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reform Brethren</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B &amp; O R. R. C.</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Myers</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Garson Myers Knoxville Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 13, 1957</u> to <u>Feb 13, 1957</u> , that I last saw the deceased alive on <u>Feb 13, 1957</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. G. F. Smith</u>		ADDRESS (Street, City or town, state) DATE SIGNED <u>2/14/57</u>	
PHYSICIAN'S NAME (Type) <u>J. G. F. Smith</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-16-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Reform</u>	22d. LOCATION (City, town, or county) (State) <u>Knoxville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. H. Tub Bruner</u>		ADDRESS <u>Md</u>	
24a. REC'D BY REGISTRAR <u>20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Eugenia Baker</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02923

## CERTIFICATE OF DEATH

02913

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rocky Ridge, MD Rural</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.#</b>				d. STREET ADDRESS <b>R.D.#</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ellen</b> Last <b>Orndorff</b>				4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 4, 1872</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>John Kass</b>			
14. MOTHER'S MAIDEN NAME <b>Ellen Neef</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>M Viola Hemler</b> Address <b>Thurmont, R.D. Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial degeneration</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>Feb 27</b> , 19 <b>55</b> , to <b>March 17</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 17</b> , 19 <b>57</b> , and that death occurred at <b>8:45 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles R Williams</b> M.D.				ADDRESS (Street, city or town, state) <b>Emmitsburg Md</b> DATE SIGNED <b>3/18/57</b>			
PHYSICIAN'S NAME (Type) <b>Charles R Williams</b>				ADDRESS <b>Emmitsburg, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/21/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Anthony's Shrine</b>		22d. LOCATION (City, town, or county) (State) <b>Emmitsburg, R.D.# MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. L. Allison</b>				ADDRESS <b>Emmitsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 20 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>A. St. Hedrick</b>							

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF CORONER</p>		<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESSES</p>		<p>15. SIGNATURE OF DECEASED</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF DECEASED</p>		<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF DECEASED</p>		<p>25. SIGNATURE OF DECEASED</p>	
<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF DECEASED</p>		<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF DECEASED</p>		<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF DECEASED</p>	
<p>36. SIGNATURE OF DECEASED</p>		<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF DECEASED</p>		<p>39. SIGNATURE OF DECEASED</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF DECEASED</p>		<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF DECEASED</p>		<p>45. SIGNATURE OF DECEASED</p>	
<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF DECEASED</p>		<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF DECEASED</p>	
<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF DECEASED</p>		<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF DECEASED</p>		<p>55. SIGNATURE OF DECEASED</p>	
<p>56. SIGNATURE OF DECEASED</p>		<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF DECEASED</p>		<p>64. SIGNATURE OF DECEASED</p>		<p>65. SIGNATURE OF DECEASED</p>	
<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF DECEASED</p>		<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF DECEASED</p>		<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF DECEASED</p>		<p>75. SIGNATURE OF DECEASED</p>	
<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF DECEASED</p>		<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF DECEASED</p>		<p>85. SIGNATURE OF DECEASED</p>	
<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF DECEASED</p>		<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF DECEASED</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF DECEASED</p>		<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF DECEASED</p>	
<p>96. SIGNATURE OF DECEASED</p>		<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF DECEASED</p>		<p>99. SIGNATURE OF DECEASED</p>		<p>100. SIGNATURE OF DECEASED</p>	

BUREAU V. E.

MAR 20, 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02914  
141

Reg. Dist. No.

02924

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Petersville</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Petersville</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Mary Catherine Palmer</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>March 14 1957</u>											
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1872</u>		<b>9. AGE</b> (In years last birthday) <u>85</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Home wife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Tandem, Va</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S. R</u>			
<b>13. FATHER'S NAME</b> <u>Simon Pickett</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Matilda Gaskins</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <u>Helen &amp; Spriggs</u> <span style="float: right;">Address <u>3089 40th St. Baltimore Md.</u></span>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>															
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <u>B. C. Thomas</u> <span style="float: right;">M.D.</span>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>									
<b>EXAMINER'S NAME (Type)</b> <u>B. C. Thomas</u>						<b>DATE SIGNED</b> <u>March 14, 1957</u>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>3-17-57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mountain</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Petersville Md</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>B. C. Thomas</u> <span style="float: right;">ADDRESS <u>Brunswick Md.</u></span>						<b>24a. REC'D BY REGISTRAR</b> <u>MAR 20 1957</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Eugenia Burke</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BALTIMORE 18

**BUREAU A. H.**

MAR 20 1957

RECEIVED

02893

## CERTIFICATE OF DEATH

Reg. Dist. No.

212

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson, Md.</u>				d. STREET ADDRESS <u>15x02</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Rebecca</u> Last <u>Poole</u>				4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 12 - 1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>16</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>6</u> Days <u>16</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>Thomas Hungenford</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Duwall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Walter Poole - Dickerson, Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction of myocardium</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>with severe coronary sclerosis</u> (c) <u>6 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/14</u> , 1957, to <u>3/16</u> , 1957, that I last saw the deceased alive on <u>3/16</u> , 1957, and that death occurred at <u>9:15 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D.				ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>3/16/57</u>			
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>				<u>Frederick Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/19/57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>				22d. LOCATION (City, town, or county) (State) <u>Bessville, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Litter</u>				ADDRESS <u>Barnesville, Md</u>			
24a. REC'D BY REGISTRAR <u>W. L. Litter</u>				24b. REGISTRAR'S SIGNATURE <u>W. L. Litter</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

MAR 21 1957

RECEIVED

02925

## CERTIFICATE OF DEATH

Reg. Dist. No.

145

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Myersville				c. LENGTH OF STAY IN lb 22yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 1				d. STREET ADDRESS Route # 1			
3. NAME OF DECEASED (Type or print) First MIDDLE LAST RUFUS CALVIN PRYOR				4. DATE OF DEATH Month Day Year March 15 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter & Handyman			10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Pryor				14. MOTHER'S MAIDEN NAME Malinda Swope			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Address Leo Powell, Myersville, Md. Rt. # 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 1999 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-55, 19, to 3-13, 1957, that I last saw the deceased alive on 3-13, 1957, and that death occurred at 10:00 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Kenneth C. Henson M.D.				ADDRESS (Street, city or town, state) Middletown, Md.		DATE SIGNED 3/15/57	
PHYSICIAN'S NAME (Type) Kenneth C. Henson				Middletown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 18, 1957		22c. NAME OF CEMETERY OR CREMATORY Grossnickle's		22d. LOCATION (City, town, or county) (State) Nr. Myersville, Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle				ADDRESS Myersville, Md.		24a. REC'D BY REGISTRAR DATE 3-17-57	
				24b. REGISTRAR'S SIGNATURE Floyd M. Bittle			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





02894

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>				c. LENGTH OF STAY IN 1b <i>2 weeks</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Mem. Hospital</i>				d. STREET ADDRESS <i>x2 Thurmont P D 2</i>			
3. NAME OF DECEASED (Type or print) First <i>Robert</i> Middle <i>Richard</i> Last <i>Byles</i>				4. DATE OF DEATH Month <i>March</i> Day <i>20</i> Year <i>1957</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 6-1901</i>	
9. AGE (In years last birthday) <i>35</i> yrs.		IF UNDER 1 YEAR Months <i>3</i> Days <i>5</i> Hours <i>5</i> Min.		IF UNDER 24 HRS. Months <i>3</i> Days <i>5</i> Hours <i>5</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>foundry</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Foundry</i>			
11. BIRTHPLACE (State or foreign country) <i>md</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			
13. FATHER'S NAME <i>John D. Byles</i>				14. MOTHER'S MAIDEN NAME <i>Ellen Jane Roberts</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>100-03-8538</i>			
17. INFORMANT <i>Mrs Mary M Byles</i>				Address <i>Thurmont md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> <i>456X</i> DUE TO <i>Pan Carditis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Lupus Erythematosus Dissem.</i> (c) <i>?</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>1. Rheumatoid Arth. 2. Subacute nephritis 3. Purgura (?)</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>5 March</i> , 1957, to <i>20 March</i> , 1957, that I last saw the deceased alive on <i>20 March</i> , 1957, and that death occurred at <i>10:10 P</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Charles H Conley, Jr</i>				ADDRESS (Street, city or town, state) <i>Professional Bldg</i>			
PHYSICIAN'S NAME (Type) <i>CHARLES H. CONLEY, JR.</i>				DATE SIGNED <i>3/22/57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>March 24-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Blue Ridge Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Frederick, md</i>				22e. (State) <i>md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond C. Bragan</i>				ADDRESS <i>Thurmont</i>		24. REG'D BY REGISTRAR <i>Ely. G. Hicks</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8225-1-1

BUREAU V. 1

MAR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02895

## CERTIFICATE OF DEATH

02918

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			c. LENGTH OF STAY IN 1b <b>17 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>102 McMurray Street</b>				d. STREET ADDRESS <b>102 McMurray Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>KARL</b> Middle <b>EMIL</b> Last <b>RABE</b>				4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>19 57</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 5, 1879</b>		
9. AGE (In years last birthday) <b>77</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Partner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Antique Shop</b>		11. BIRTHPLACE (State or foreign country) <b>Copenhagen, Denmark</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Unknown</b>				
14. MOTHER'S MAIDEN NAME <b>Unknown</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO. <b>103-12-3789</b>				17. INFORMANT <b>Mrs. Nora Jane D. Rabe, 102 McMurray Street, Frederick, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Esophagus</b> <b>152x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) <b>Frederick</b>				20g. (County) <b>Maryland</b>				
21. I certify that I attended the deceased from <b>5-1</b> , 19 <b>57</b> , to <b>3-31</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-31</b> , 19 <b>57</b> , and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>U. J. Bourne Jr.</b>				M.D. <b>All Saints Street, Frederick, Md.</b>				
DATE SIGNED <b>4/2/1957</b>				PHYSICIAN'S NAME (Type) <b>Dr. U. G. Bourne Jr.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>April 3, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		
22d. LOCATION (City, town, or county) <b>Frederick</b>				(State) <b>Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>3 April 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>		

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician		11. Signature of Registrar		12. Date of Registration	
JAMES EARL RAY		Male		White		12-1-29		4-4-68		Memphis, Tenn.		Memphis, Tenn.		Gunshot wound		Suicide		JAMES EARL RAY		JAMES EARL RAY		4-4-68	
13. Occupation		14. Education		15. Marital Status		16. Social Security No.		17. Hospital		18. Physician		19. Coroner		20. Burial Place		21. Burial Date		22. Burial Time		23. Burial Place		24. Burial Time	
Attorney		High School		Single		66-01-1234		St. Louis Hospital		Dr. J. H. Smith		Dr. J. H. Smith		St. Louis Cemetery		4-4-68		4-4-68		4-4-68		4-4-68	
25. Signature of Deceased		26. Signature of Next of Kin		27. Signature of Registrar		28. Signature of Physician		29. Signature of Coroner		30. Signature of Burial Place		31. Signature of Burial Time		32. Signature of Burial Place		33. Signature of Burial Time		34. Signature of Burial Place		35. Signature of Burial Time		36. Signature of Burial Place	

BUREAU V. 3

APR 4 1957

RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02919

02896

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12 West Seventh Street</b>		d. STREET ADDRESS <b>12 West Seventh Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM GARFIELD REEDER</b>		4. DATE OF DEATH Month Day Year <b>March 6, 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 Nov 1881</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Sexton</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Josephus Reeder</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Bear</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-18-8365A</b>	
17. INFORMANT <b>Mrs. Hattie V. Reeder</b> Address <b>(Same as item #1)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1, 1957</b> , to <b>March 6, 1957</b> , that I last saw the deceased alive on <b>March 5, 1957</b> , and that death occurred at <b>10:17 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>228 N. Market St., Frederick, Md. 3-8-57</b> ACTUAL SIGNATURE <b>Bernard O. Thomas, Jr., M.D.</b> PHYSICIAN'S NAME (Type) <b>Bernard O. Thomas, Jr., M.D.</b>			
22a. BURIAL, CREMATION, OR OTHER FINAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9 March 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middlebrook, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>11 March 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>			



CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BIRTH [Faint text]	
OCCASION OF DEATH [Faint text]		PREVIOUS ILLNESS [Faint text]		PREVIOUS SURGERY [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]	
DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]	

BUREAU T. 1

MAR 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02920

02926

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Mr. Lander</b>				c. LENGTH OF STAY IN 1b <b>about 5 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenmerrie Nursing Home</b>				d. STREET ADDRESS <b>Francis Scott Key Hotel</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Henry</b> Last <b>Riggs</b>				4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-20-1870</b>		9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Medical Doctor</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Christopher Mussetter Riggs</b>				14. MOTHER'S MAIDEN NAME <b>Angeline LaBarre</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Geo. H. Riggs-Jr. Ashton-Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with Congestive Failure</b> DUE TO (c) <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Frederick</b>				20g. (County) <b>Maryland</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>Nov. 3, 1956</b> to <b>March 10, 1957</b> , that I last saw the deceased alive on <b>March 9, 1957</b> , and that death occurred at <b>3 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. A. Pearre</b>				ADDRESS (Street, city or town and state) <b>Frederick, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. A. A. Pearre</b>				DATE SIGNED <b>E. Church St.-Frederick-Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-12-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>				ADDRESS <b>Frederick-Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 13 March 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>			

BUREAU A. 3

MAR 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 214 4 20 57

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02921

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. STATE <b>Maryland</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>John Mellinger Sausser</b>		4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 2 1920</b>
9. AGE (In years last birthday) <b>36</b> yrs.		IF UNDER 1 YEAR Months <b>36</b> Days <b>36</b> Hours <b>36</b> Min. <b>36</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electric Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James R. Sausser</b>		14. MOTHER'S MAIDEN NAME <b>Clara W. Mellinger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWII</b>		16. SOCIAL SECURITY NO. <b>212-14-6882</b>	
17. INFORMANT <b>Clara W. Sausser</b>		Address <b>Braddock Heights, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>hrs.</b> <b>yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. Thomas</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>March 21, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>22 March 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Denver, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>22 March 1957 - Elizabeth B. Heck</b>	
24b. REGISTRAR'S SIGNATURE			

BUREAU V. S.

MAR 26 1957

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02922

02897

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 239 West Patrick Street				d. STREET ADDRESS 239 West Patrick Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Carrie Estelle Shafer				4. DATE OF DEATH Month Day Year March 16 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 23-1886	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Andrew Clay McBride				14. MOTHER'S MAIDEN NAME Annie E. Routzahn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Richard E. Snyder (daughter) 239 W. Patrick St., Frederick-Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 20 minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frederick (County) (State)							
21. I certify that I attended the deceased from May 1950, to March 16, 1957, that I last saw the deceased alive on March 14, 1957, and that death occurred at 8:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE B. O. Thomas				ADDRESS (Street, city or town, state) Professional Bldg.-Frederick-Md.			
PHYSICIAN'S NAME (Type) Dr. B.O. Thomas-Sr.				DATE SIGNED 3/18/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-19-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick-Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. C. E. Cline & Son				ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR 19 March 1957	
						24b. REGISTRAR'S SIGNATURE Elizabeth Y. Heub	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1. NAME OF DECEASED HOLLY, J. J.		2. SEX Male		3. AGE 30	
4. DATE OF DEATH Dec 23, 1957		5. TIME OF DEATH 10:00 PM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. DATE OF BIRTH Dec 23, 1927		11. TIME OF BIRTH 10:00 PM		12. PLACE OF BIRTH Baltimore, Md.	
13. NAME OF FATHER J. J. Holly		14. NAME OF MOTHER J. J. Holly		15. NAME OF SPOUSE J. J. Holly	
16. NAME OF NEXT OF KIN J. J. Holly		17. NAME OF PHYSICIAN J. J. Holly		18. NAME OF BURIAL PLACE J. J. Holly	
19. NAME OF FUNERAL HOME J. J. Holly		20. NAME OF CEMETERY J. J. Holly		21. NAME OF INTERMENT J. J. Holly	
22. NAME OF CORPSE J. J. Holly		23. NAME OF CLOTHING J. J. Holly		24. NAME OF ACCESSORIES J. J. Holly	
25. NAME OF PROPERTY J. J. Holly		26. NAME OF VEHICLES J. J. Holly		27. NAME OF OTHER ASSETS J. J. Holly	
28. NAME OF LIABILITIES J. J. Holly		29. NAME OF OTHER ASSETS J. J. Holly		30. NAME OF OTHER ASSETS J. J. Holly	
31. NAME OF OTHER ASSETS J. J. Holly		32. NAME OF OTHER ASSETS J. J. Holly		33. NAME OF OTHER ASSETS J. J. Holly	
34. NAME OF OTHER ASSETS J. J. Holly		35. NAME OF OTHER ASSETS J. J. Holly		36. NAME OF OTHER ASSETS J. J. Holly	
37. NAME OF OTHER ASSETS J. J. Holly		38. NAME OF OTHER ASSETS J. J. Holly		39. NAME OF OTHER ASSETS J. J. Holly	
40. NAME OF OTHER ASSETS J. J. Holly		41. NAME OF OTHER ASSETS J. J. Holly		42. NAME OF OTHER ASSETS J. J. Holly	
43. NAME OF OTHER ASSETS J. J. Holly		44. NAME OF OTHER ASSETS J. J. Holly		45. NAME OF OTHER ASSETS J. J. Holly	
46. NAME OF OTHER ASSETS J. J. Holly		47. NAME OF OTHER ASSETS J. J. Holly		48. NAME OF OTHER ASSETS J. J. Holly	
49. NAME OF OTHER ASSETS J. J. Holly		50. NAME OF OTHER ASSETS J. J. Holly		51. NAME OF OTHER ASSETS J. J. Holly	
52. NAME OF OTHER ASSETS J. J. Holly		53. NAME OF OTHER ASSETS J. J. Holly		54. NAME OF OTHER ASSETS J. J. Holly	
55. NAME OF OTHER ASSETS J. J. Holly		56. NAME OF OTHER ASSETS J. J. Holly		57. NAME OF OTHER ASSETS J. J. Holly	
58. NAME OF OTHER ASSETS J. J. Holly		59. NAME OF OTHER ASSETS J. J. Holly		60. NAME OF OTHER ASSETS J. J. Holly	
61. NAME OF OTHER ASSETS J. J. Holly		62. NAME OF OTHER ASSETS J. J. Holly		63. NAME OF OTHER ASSETS J. J. Holly	
64. NAME OF OTHER ASSETS J. J. Holly		65. NAME OF OTHER ASSETS J. J. Holly		66. NAME OF OTHER ASSETS J. J. Holly	
67. NAME OF OTHER ASSETS J. J. Holly		68. NAME OF OTHER ASSETS J. J. Holly		69. NAME OF OTHER ASSETS J. J. Holly	
70. NAME OF OTHER ASSETS J. J. Holly		71. NAME OF OTHER ASSETS J. J. Holly		72. NAME OF OTHER ASSETS J. J. Holly	
73. NAME OF OTHER ASSETS J. J. Holly		74. NAME OF OTHER ASSETS J. J. Holly		75. NAME OF OTHER ASSETS J. J. Holly	
76. NAME OF OTHER ASSETS J. J. Holly		77. NAME OF OTHER ASSETS J. J. Holly		78. NAME OF OTHER ASSETS J. J. Holly	
79. NAME OF OTHER ASSETS J. J. Holly		80. NAME OF OTHER ASSETS J. J. Holly		81. NAME OF OTHER ASSETS J. J. Holly	
82. NAME OF OTHER ASSETS J. J. Holly		83. NAME OF OTHER ASSETS J. J. Holly		84. NAME OF OTHER ASSETS J. J. Holly	
85. NAME OF OTHER ASSETS J. J. Holly		86. NAME OF OTHER ASSETS J. J. Holly		87. NAME OF OTHER ASSETS J. J. Holly	
88. NAME OF OTHER ASSETS J. J. Holly		89. NAME OF OTHER ASSETS J. J. Holly		90. NAME OF OTHER ASSETS J. J. Holly	
91. NAME OF OTHER ASSETS J. J. Holly		92. NAME OF OTHER ASSETS J. J. Holly		93. NAME OF OTHER ASSETS J. J. Holly	
94. NAME OF OTHER ASSETS J. J. Holly		95. NAME OF OTHER ASSETS J. J. Holly		96. NAME OF OTHER ASSETS J. J. Holly	
97. NAME OF OTHER ASSETS J. J. Holly		98. NAME OF OTHER ASSETS J. J. Holly		99. NAME OF OTHER ASSETS J. J. Holly	
100. NAME OF OTHER ASSETS J. J. Holly		101. NAME OF OTHER ASSETS J. J. Holly		102. NAME OF OTHER ASSETS J. J. Holly	

BUREAU V. S.

MAR 22 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02898

## CERTIFICATE OF DEATH

Reg. Dist. No.

02923

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> //			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>23 W. 7th St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Etta</u> Middle <u>L.</u> Last <u>Shepley</u>				4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/1893</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S.</u>	
13. FATHER'S NAME <u>John Sliker</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Keeler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-24-5945</u>		17. INFORMANT <u>Charles E. Shepley, 23 W. 7th St., Fred., Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Hypertension</u> DUE TO (c) <u>Generalized arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>hour</u> <u>year</u> <u>year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>7-26</u> , 19 <u>55</u> , to <u>3-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-1</u> , 19 <u>56</u> , and that death occurred at <u>5:00</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert S. Turner, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>7 East Church St.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>Dr. Robert S. Turner, Jr.</u>				Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>27 March 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 28 1957

BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02928

## CERTIFICATE OF DEATH

Reg. Dist. No.

02924

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>		c. LENGTH OF STAY IN 1b <u>15 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY</u> <u>MONROE</u> <u>STALEY</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>28</u> <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 28, 1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hiram Staley</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Van Fossen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mrs. Virginia Staley, Walkersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis &amp; myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis &amp; right hemiplegia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>19</u>				20g. (County) <u>19</u>		20h. (State) <u>19</u>	
21. I certify that I attended the deceased from <u>1 April</u> , 19 <u>57</u> , to <u>28 March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>28 March</u> , 19 <u>57</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James S. Stoner Jr.</u>				ADDRESS (Street, city or town, state) <u>WALKERSVILLE Md.</u>			
PHYSICIAN'S NAME (Type) <u>JAMES F STONER JR</u>				DATE SIGNED <u>28 March 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 31, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>M. Libertytown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton, Walkersville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>1 April 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth L. Heck</u>	



BUREAU V. 5

APR 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02925

02903

## CERTIFICATE OF DEATH

Reg. Dist. No.

141

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 524 Brunswick Street		d. STREET ADDRESS 1 524 Brunswick Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Violet L Staub		4. DATE OF DEATH Month 3 Day 19 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-1897
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Bolitho		14. MOTHER'S MAIDEN NAME Edith Knight	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John Thomas Staub, Brunswick, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C.E. Pruitt		M.D. _____ ADDRESS (Street, city or town, state) DATE SIGNED 3-21-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-21-1957	
22c. NAME OF CEMETERY OR CREMATORY Fair View		22d. LOCATION (City, town, or county) (State) Harpers Ferry, West Va.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Lu Fante		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Eugene Burkes	
DATE MAR 26 1957			

BUREAU V. S.

APR 23 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02929

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02926

Reg. Dist. No.

141

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Knocksville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Knocksville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>7</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carrie Mae Stevens</u>				4. DATE OF DEATH Month Day Year <u>March 18 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 25, 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>Charley Moss</u>				14. MOTHER'S MARYEN NAME <u>Katie Mae Moss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Harry Lee Stevens</u> Address <u>Knocksville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio Sclerosis</u> (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>5 yrs +</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>B.D. Thomas</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>B.D. Thomas</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 18, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Locust Valley</u>		22d. LOCATION (City, town, or county) (State) <u>Burkittsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Feete &amp; Bros., Brunswick, Maryland</u>				24a. REC'D BY REGISTRAR <u>MAR 26 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Eugenia Burkitt</u>			

RECEIVED

MAR 26 1957

BUREAU V. S.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

02930

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02927

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>65 South Market</b>	
3. NAME OF DECEASED (Type or print) First <b>Carl</b> Middle <b>Junior</b> Last <b>Stine</b>		4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1919</b>
9. AGE (In years last birthday) <b>37</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>sewer construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Amos C. Stine</b>		14. MOTHER'S MAIDEN NAME <b>Nellie E. Knadler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>W.W.11</b>		16. SOCIAL SECURITY NO. <b>219-05-2801</b>	
17. INFORMANT <b>Amos C. Stine, Middletown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation</b> <b>925.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Working in deep ditch the earth caved in &amp; he was buried</b>	
20c. TIME OF INJURY Hour <b>1</b> p. m. <b>3/11/57</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>	20f. (City or town) (County) (State) <b>Middletown Frederick, Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		DATE SIGNED <b>March 12, 1957</b>	
EXAMINER'S NAME (Type) <b>B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/14/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>		24a. REC'D BY REGISTRAR <b>14 March 1957</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Elizabeth H. Heck</b>	

RECEIVED

MAR 18 1957

BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02899

## CERTIFICATE OF DEATH

02928

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Thore Pines Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BERT</b> Middle <b>STRUBE</b> Last <b>STRUBE</b>		4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 18, 1880</b>
9. AGE (In years last birthday) yrs. <b>76</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Andrew Strube</b>	
14. MOTHER'S MAIDEN NAME <b>Rosa Schradel</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Albert Strube, Frederick R.F.D.#2, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senility</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cancer of prostate, question of</b> DUE TO (c) <b>1 yr.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 1956, to <b>3-21</b> , 1957, that I last saw the deceased alive on <b>3-14</b> , 1957, and that death occurred at <b>6:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>East Church St., Frederick, Md.</b> DATE SIGNED <b>3/22/1957</b>			
ACTUAL SIGNATURE <b>R. R. Martin</b>		M.D. <b>East Church St., Frederick, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Rex R. Martin</b>		Same as above	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 23, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>22 March 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		MARRIAGE	
AGE AT DEATH		DATE OF BIRTH	
SEX		RACE	
EDUCATION		OCCUPATION	
RELIGION		MANNER OF DEATH	
CAUSE OF DEATH		IMMEDIATE CAUSE	
DISEASE OR INJURY		PERIOD OF ILLNESS	
TREATMENT		HISTORY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

**RECEIVED**  
 MAR 26 1957  
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02931

CERTIFICATE OF DEATH

02929

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#2</b>				c. LENGTH OF STAY IN 1b <b>22 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ball Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>(Also known as Harry E. Stupp) HARRY EDWARD STUP</b>				4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>29 Oct 1893</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Well Driller</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lime Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Samuel Edward Stup</b>			
14. MOTHER'S MAIDEN NAME <b>Odesa Null</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>214-10-4062</b>				17. INFORMANT <b>Mrs. Mary E. Stup</b> Address (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Frederick, Maryland</b>				20g. (County) (State)			
21. I certify that I attended the deceased from <b>March 7</b> , 1957, to <b>March 12</b> , 1957, that I last saw the deceased alive on <b>March 12</b> , 1957, and that death occurred at <b>3 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. <b>228 N. Market St., Frederick, Md.</b> DATE SIGNED <b>3-15-57</b>			
PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>15 March 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>15 March 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Hobbs</b>	



# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 2

MAR 18 1957

RECEIVED

NAME OF DECEASED [Faint text, possibly "JOHN J. BROWN"]		SEX [Faint text, possibly "Male"]	
DATE OF BIRTH [Faint text, possibly "1910-01-01"]		PLACE OF BIRTH [Faint text, possibly "Boston, Mass."]	
DATE OF DEATH [Faint text, possibly "1957-03-15"]		PLACE OF DEATH [Faint text, possibly "Boston, Mass."]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
OCCASION OF DEATH [Faint text, possibly "Natural Causes"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF DECEASED [Faint text, possibly "John J. Brown"]		SIGNATURE OF WITNESS [Faint text, possibly "John J. Brown"]	
SIGNATURE OF PHYSICIAN [Faint text, possibly "John J. Brown"]		SIGNATURE OF CORONER [Faint text, possibly "John J. Brown"]	
SIGNATURE OF REGISTRAR [Faint text, possibly "John J. Brown"]		SIGNATURE OF CLERK [Faint text, possibly "John J. Brown"]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02930

02932

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Braddock Heights</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Winchester</i>		d. STREET ADDRESS <i>—</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John</i> First <i>Edgar</i> Middle <i>Sulzer</i> Last		4. DATE OF DEATH <i>3</i> Month <i>9</i> Day <i>1957</i> Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-21-1882</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>George P. Sulzer</i>		14. MOTHER'S MAIDEN NAME <i>Catherine</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Chas. E. Kinna</i> Address <i>Frederick, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO <i>5 yrs.</i> (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/15</i> , 19 <i>56</i> , to <i>3/9</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>3/8</i> , 19 <i>57</i> , and that death occurred at <i>7 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry V Chase</i> M.D. <i>4 E. Church St</i> ADDRESS (Street, city or town, state)		DATE SIGNED <i>3/10/57</i>	
PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>		<i>Frederick Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-12-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Katherine</i>		22d. LOCATION (City, town, or county) (State) <i>Jefferson Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>—</i> ADDRESS <i>—</i>		24a. REC'D BY REGISTRAR <i>—</i> 24b. REGISTRAR'S SIGNATURE <i>—</i>	
DATE <i>—</i>		DATE <i>MAR 15 1957</i>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

PLACE OF BIRTH

CAUSE OF DEATH

PLACE OF BIRTH

CAUSE OF DEATH

PLACE OF BIRTH

CAUSE OF DEATH

BUREAU V. S.

MAR 15 1957

RECEIVED

02900

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont-R.D.#1</b>				c. LENGTH OF STAY IN TB <b>10 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLOTTE</b> Middle <b>ELIZABETH</b> Last <b>TURNER</b>				4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 11, 1901</b>	
9. AGE (In years lost birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Lewis A. Moberly</b>				14. MOTHER'S MAIDEN NAME <b>Bessie M. Cramer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mr. Warren H. Turner, Thurmont, R.D.#1, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial pneumonia &amp; lung abscess</b> DUE TO <b>Chronic pyelonephritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>AGNOSIS LEFT KIDNEY</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>30 YEARS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>WALKERSVILLE, Md.</b>				20g. (County) <b>Frederick</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>1 Mar</b> , 19 <b>56</b> , to <b>8 March</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8 March</b> , 19 <b>57</b> , and that death occurred at <b>8:35 AM</b> , from the causes and on the date stated above. DATE SIGNED <b>8 March 1957</b> ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <b>James E. Stover Jr.</b> M.D. <b>WALKERSVILLE, Md.</b> PHYSICIAN'S NAME (Type) <b>JAMES E. STOVER, JR.</b> Same as above							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 11, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE 11 March 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Heck</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. 1

MAR 12 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02932

02901

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>WASHINGTON</b> Last <b>TYERYAR, SR.</b>				4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 Oct 1888</b>	9. AGE (In years last birthday) yrs. <b>68</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Rudolph Tyeryar</b>				14. MOTHER'S MAIDEN NAME <b>Alice Virginia Phelps</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-26-6120</b>		17. INFORMANT Address <b>Mrs. Mary E. Tyeryar (Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Coronary Thrombosis</b> DUE TO (c) <b>Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>3/6/</b> 19 <b>57</b> , to <b>3/9/</b> 19 <b>57</b> , that I last saw the deceased alive on <b>3/9/</b> 19 <b>57</b> , and that death occurred at <b>8 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 E. Church St., Frederick, Md.</b> DATE SIGNED <b>3-12-57</b> ACTUAL SIGNATURE <b>A. A. Pearre</b> M.D. PHYSICIAN'S NAME (Type) <b>A. A. Pearre, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>13 March 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>12 March 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		1892		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
LABORER		HEART DISEASE		NATURAL		10 DAYS		MARCH 12, 1957		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
EDUCATION		SCHOOLING		RELIGION		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		COUNTY		STATE	
HIGH SCHOOL		8 YEARS		METHODIST		MARRIED		1915		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S STATE	
JAMES H. HARRIS		MARY H. HARRIS		LABORER		HOUSEWIFE		1885		1890		BALTIMORE		BALTIMORE		BALTIMORE	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S STATE		MOTHER'S STATE		FATHER'S CITY		MOTHER'S CITY		FATHER'S COUNTY	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY	
MARCH 12, 1957		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MARCH 12, 1957		BALTIMORE		BALTIMORE		BALTIMORE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		MARY H. HARRIS		JAMES H. HARRIS		MARY H. HARRIS		JAMES H. HARRIS		MARY H. HARRIS		JAMES H. HARRIS		MARY H. HARRIS		JAMES H. HARRIS	

BUREAU V. S.

MAR 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02932

## CERTIFICATE OF DEATH

Reg. Dist. No.

02933

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 231 Dill Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Cora R. Waltz		4. DATE OF DEATH Month March Day 5 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 25-1893
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Retail Store	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Franklin E. Smith		14. MOTHER'S MAIDEN NAME Mary C.E. Krantz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-16-0950	
17. INFORMANT Wilson W. Waltz-302 N. Coll. Prkway-Frederick-Md.		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion (2) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH days & hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/5, 1957, to 3/5, 1957, that I last saw the deceased alive on 3/5, 1957, and that death occurred at 4:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James B. Thomas, M.D. Professional Bldg.-Frederick-Md. PHYSICIAN'S NAME (Type) Dr. James B. Thomas			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 8-1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick-Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. C. E. Cline & Son		ADDRESS Frederick-Maryland	
24a. REC'D BY REGISTRAR DATE 9 March 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Sex		Age		Date of Birth	
Place of Birth		Race		Marital Status		Occupation	
Cause of Death		Immediate Cause		Underlying Cause		Contributing Cause	
Date of Death		Time of Death		Place of Death		Manner of Death	
Physician's Signature		Physician's License No.		Medical Examiner's Signature		Medical Examiner's License No.	
Hospital or Institution		City		County		State	

BUREAU V. 5

MAR 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02903

02934

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>912 Motter Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>TERRY</b> Middle <b>LEE</b> Last <b>WEDDLE</b>				4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>19 57</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>14 March 1957</b>		9. AGE (In years last birthday) yrs. <b>3</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William K. Weddle</b>				14. MOTHER'S MAIDEN NAME <b>Helen Louise Bartlett</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>William K. Weddle</b>				Address <b>(Same as item #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fetal Atelectasis</b> <b>762.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <b>From birth</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Frederick</b>		(County) <b>Frederick</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>14 March</b> , 19 <b>57</b> , to <b>17 March</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>17 March</b> , 19 <b>57</b> , and that death occurred at <b>3:25A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>220 N. Market St., Frederick, Md.</b> DATE SIGNED <b>3-18-57</b> ACTUAL SIGNATURE <b>A. M. Powell</b> PHYSICIAN'S NAME (Type) <b>Albert M. Powell, Jr., M. D.</b>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>18 March 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>						ADDRESS <b>Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>18 March 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>			

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02904

## CERTIFICATE OF DEATH

02935

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>17 E. 5 St.</b>				d. STREET ADDRESS <b>17 E 5th St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>August</b> Last <b>Wedel Heinen</b>				4. DATE OF DEATH Month <b>3</b> Day <b>7</b> Year <b>57</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1869</b>		9. AGE (In years last birthday) <b>87</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212 14 1933</b>		17. INFORMANT <b>Mr. Maurice Tillery</b>		Address <b>Balto., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senility</b> <b>794X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>2-3 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 7, 1954</b> , to <b>March 7, 1957</b> , that I last saw the deceased alive on <b>Feb 28, 1957</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. R. Martin</b>				ADDRESS (Street, city or town, state) <b>35 E Church Frederick</b>			
PHYSICIAN'S NAME (Type) <b>RECK R MARTIN</b>				DATE SIGNED <b>3-7-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/9/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Brooklyn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes</b>				ADDRESS <b>130 E. Fort Ave.</b>		24a. REC'D BY REGISTRAR <b>Thy. G. Hicks</b>	
				DATE <b>MAR 11 1957</b>		24b. REGISTRAR'S SIGNATURE	

1999

MAR 11 1957

RECEIVED

02905

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>W. Jacob</b> Middle <b>Elmer</b> Last <b>Weller</b>		4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 29, 1861</b>
9. AGE (In years last birthday) <b>95</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman-Main. Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West. Md. RR</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Clarence Long</b>		Address <b>Creagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardio-vascular</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Disease with Congestive Failure</b> DUE TO (c) <b>Sensitivity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 3, 1957</b> , to <b>March 6, 1957</b> , that I last saw the deceased alive on <b>March 6, 1957</b> , and that death occurred at <b>1 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. A. Pearre</b>		DATE SIGNED <b>3/6/57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. A.A. pearre</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-9-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westminster Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Guager</b>		24a. REC'D BY REGISTRAR <b>Thurmont</b>	
24b. REGISTRAR'S SIGNATURE <b>Bliz G. Hicks</b>		DATE <b>8 1957</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



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1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
02933 Item 2 Film G212 3-27-57 et  
CERTIFICATE OF DEATH

Reg. Dist. No. 137

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Frederick				c. LENGTH OF STAY IN 1b 7 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montevue County Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harry L. Wenzel				4. DATE OF DEATH March 14 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-14-1893	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel kitchen work		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lewis P. Wenzel				14. MOTHER'S MAIDEN NAME Annie Brightwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) World War I		16. SOCIAL SECURITY NO. 212-14-8834		17. INFORMANT Charles H. Wenzel (brother) Nr. Creagerstown-Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic alcoholism DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 min. 2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frederick (County) Frederick (State) Maryland				20g. (City or town) Frederick (County) Frederick (State) Maryland			
21. I certify that I attended the deceased from Oct 1956, to Mar 1957, that I last saw the deceased alive on Feb 1957, and that death occurred at 7:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Horace F. Kline				ADDRESS (Street, city or town, state) 7 N. Market St.-Frederick-Maryland			
PHYSICIAN'S NAME (Type) Dr. Horace F. Kline				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick-Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son				ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE 18 March 1957	
				24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck			

BUREAU V. S.

MAR 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
02906 Item 8 FilmG212 3-13-57 et											
CERTIFICATE OF DEATH											
Reg. Dist. No. 02938 131											
1. PLACE OF DEATH o. COUNTY Frederick MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 South Court Street						d. STREET ADDRESS 22 South Court Street					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Leroy First Middle Last Wilson						4. DATE OF DEATH March 4 1957					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 28-1895/1894		9. AGE (In years (day birthday) yrs. 62		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) utility - rug store				10b. KIND OF BUSINESS OR INDUSTRY *****				11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George W. Wilson						14. MOTHER'S MAIDEN NAME Elvina Smith					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes W.W.I				16. SOCIAL SECURITY NO. 214-10-1655		17. INFORMANT Mary Ellen Wilson --22 S. Court St. Fred. Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Atherosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 8-9 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 1955, to March 4, 1957, that I last saw the deceased alive on March 1, 1957, and that death occurred at 7:30 A.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE Rex R. Martin M.D.						ADDRESS (Street, city or town, state) 35 East Church Street Frederick, Md. DATE SIGNED 3-4-57					
PHYSICIAN'S NAME (Type) Rex R. Martin						35 East Church Street Frederick, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-7-57		22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town, or county) (State) Frederick, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III Frederick, Md.						24a. REC'D BY REGISTRAR DATE 6 March 1957		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck			

BUREAU V. S.

MAR 7 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02907 CERTIFICATE OF DEATH

02939

Reg. Dist. No. | 3 |

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>25 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mr. Claude A. Wilt</b> First Middle Last		4. DATE OF DEATH <b>March 30 1957</b> Month Day Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-2-1877</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U..S.</b>	
13. FATHER'S NAME <b>John Wilt</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Franklin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Ruby Wilt, R.D. Union Bridge, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Arteriosclerosis + Senility</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>904.0</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Compression Fracture Lumbar 1 - Result of Fall</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>was senile and had fall in his home.</b>	
20c. TIME OF INJURY Month, Day, Year <b>March 1 1957</b> Hour of m. <b>about 11</b> a.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>M. Gary Canal Rd</b> (County) (State)	
21. I certify that I attended the deceased from <b>March 5, 1957</b> , to <b>March 30, 1957</b> , that I last saw the deceased alive on <b>March 30, 1957</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. A. Pearre</b> M.D.		ADDRESS (Street, city or town, state) <b>Frederick, Md.</b> DATE SIGNED <b>3/30/57</b>	
PHYSICIAN'S NAME (Type) <b>A. A. PEARRE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4-2-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Linganore</b>	22d. LOCATION (City, town, or county) (State) <b>Unionville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.M. Waltz,</b> ADDRESS <b>Winfield, Maryland</b>		24a. REC'D BY REGISTRAR <b>2 April 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Hech</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIED		SINGLE		WIDOW		DIVORCED		OTHER	
WHITE		WHITE		METHODIST		MARRIED		SINGLE		WIDOW		DIVORCED		OTHER	
EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL		HOME		BALTIMORE		MARYLAND		UNITED STATES	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH		THIRD OF DEATH		FOURTH OF DEATH		FIFTH OF DEATH	
APR 4 1968		10:15 AM		10:15		10:15		10:15		10:15		10:15		10:15	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CLERGY		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL	
DATE OF INTERVIEW		TIME OF INTERVIEW		PLACE OF INTERVIEW		CITY		STATE		COUNTRY		INTERVIEWER		SUPERVISOR	
APR 5 1968		10:15 AM		HOME		BALTIMORE		MARYLAND		UNITED STATES		J. E. RAY		J. E. RAY	

BUREAU V. 2

APR 3 1957

RECEIVED